National Electronic Data Interchange Transaction Set Implementation Guide

Health Care Eligibility Benefit Inquiry and Response

270/271

ASC X12N 270/271 (004010X092)

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1 Purpose and Business Overview

1.1 Document Purpose

For the health care industry to achieve the potential administrative cost savings with Electronic Data Interchange (EDI), standards have been developed and need to be implemented consistently by all organizations. To facilitate a smooth transition into the EDI environment, uniform implementation is critical.

The purpose of this implementation guide is to explain the developers' intent when the Health Care Eligibility, Coverage, or Benefit Inquiry (270) and Health Care Eligibility, Coverage, or Benefit Information (271) transaction sets were designed and to give guidance on how they should be implemented in the health care industry. Specifically, this guide defines where data is put and when it is included for the ANSI ASC X12.281 and X12.282 transaction sets for the purpose of conveying health care eligibility and benefit information. This paired transaction set is comprised of two transactions: the 270, which is used to request (inquire) information, and the 271, which is used to respond with coverage, eligibility, and benefit information. The official names for these transactions are:

ANSI ASC X12.281 - Eligibility, Coverage, or Benefit Inquiry (270)

ANSI ASC X12.282 - Eligibility, Coverage, or Benefit Information (271)

This implementation guide is intended to provide assistance in the development and use of the electronic transfer of health care eligibility and benefit information. It is hoped that the entities that exchange eligibility information will work to develop and exchange standard formats within the health care industry and among their trading partners.

1.1.1 HIPAA Role in Implementation Guides

The Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191 - known as HIPAA) includes provisions for Administrative Simplification, which require the Secretary of Department of Health and Human Services to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

Detailed Implementation Guides for each standard must be available at the time of the adoption of HIPAA standards so that health plans, providers, clearinghouses, and software vendors can ready their information systems and application software for compliance with the standards. Consistent usage of the standards, including loops, segments, data elements, etc., across all guides is mandatory to support the Secretary's commitment to standardization.

This Implementation Guide has been developed for use as a HIPAA Implementation Guide for Eligibility for a Health Plan. Should the Secretary adopt the X12N 270/271 Health Care Eligibility Benefit Inquiry and Response transactions as an industry standard, this Implementation Guide describes the consistent industry

usage called for by HIPAA. If adopted under HIPAA, the X12 270/271 Health Care Eligibility Benefit Inquiry and Response transactions cannot be implemented except as described in this Implementation Guide.

1.1.2 Trading Partner Agreements

It is appropriate and prudent for payers to have trading partner agreements that go with the standard Implementation Guides. This is because there are 2 levels of scrutiny that all electronic transactions must go through.

First is standards compliance. These requirements MUST be completely described in the Implementation Guides for the standards, and NOT modified by specific trading partners.

Second is the specific processing, or adjudication, of the transactions in each trading partner's individual system. Since this will vary from site to site (e.g., payer to payer), additional documentation which gives information regarding the processing, or adjudication, will prove helpful to each site's trading partners (e.g., providers), and will simplify implementation.

It is important that these trading partner agreements NOT:

- Modify the definition, condition, or use of a data element or segment in the standard Implementation Guide
- Add any additional data elements or segments to this Implementation Guide
- Utilize any code or data values which are not valid in this Implementation Guide
- Change the meaning or intent of this Implementation Guide

These types of companion documents should exist solely for the purpose of clarification, and should not be required for acceptance of a transaction as valid.

1.1.3 About the Authors

This transaction set and implementation guide have been developed by the Eligibility Work Group (WG1) which is part of the Health Care Task Group (TG2) within Insurance Subcommittee of X12 (X12N), which is an Accredited Standards Committee (ASC) under ANSI (American National Standards Institute). X12 is responsible for writing transaction standards for EDI. WG1 is comprised of numerous representatives from the health industry, including:

- health insurance companies
- health care providers
- health care systems vendors
- information network providers
- independent health care consultants
- state and federal health agencies
- translation software vendors

This implementation guide represents the best efforts of these organizations to bring forward the information and business requirements associated with this business process. As new or refined business requirements are identified, changes to this implementation guide will be made through this WG. Anyone

wishing to make changes or additions to this implementation guide should contact one of the co-chairs of the WG. Co-chairs are listed with DISA (Data Interchange Standards Association), which is the secretariat for X12.

1.2 Version and Release

This implementation guide is based on the October 1997 ASC X12 standards, referred to as Version 4, Release 1, Sub-release 0 (004010). These transactions were approved by ASC X12 as a Draft Standard for Trial Use (DSTU) in February 1993. This document is available from Washington Publishing Company.

The implementation guide for Version 3 release 5.1 (003051) written by WEDI (the Work Group on Electronic Data Interchange) and dated January 1996 was used as the foundation for this document. Changes were made to the transaction set in version 003052 for the Property and Casualty, and Worker's Compensation industries. The X12 community also made changes to the NM1, REF, PRV, EQ, and INS segments for other industries. Changes made to the PRV segment directly affect the 270/271 transaction sets. Changes to the INS segment have added functions, one of which has been adopted by the Eligibility Work Group. All other segments that have changes do not affect the implementation of 270/271 transaction sets. This implementation guide also reflects changes that were suggested by industry review and the ASC X12N TG2 WG1 since the WEDI implementation guide was published.

1.3 Business Use and Definition

1.3.1 Background Information

Providers of medical services must currently submit health care eligibility and benefit inquiries in a variety of methods, either on paper, via phone, or electronically. The information requirements vary depending upon:

- type of insurance plan
- type of service performed
- where the service is performed
- where the inquiry is initiated
- where the inquiry is sent

The Health Care Coverage, Eligibility, and Benefit transactions are designed so that inquiry submitters (information receivers) can determine (a) whether an information source organization (e.g., payer, employer, HMO) has a particular subscriber or dependent on file, and (b) the health care eligibility and/or benefit information about that subscriber and/or dependent(s). The data available through these transaction sets is used to verify an individual's eligibility and benefits, but cannot provide a history of benefit use. The information source organization may provide information about other organizations that may have third party liability for coordination of benefits.

To accomplish this, two Health Care Coverage, Eligibility, and Benefit transaction sets are used. The two batch-oriented ASC X12 transaction sets are:

- Health Care Coverage, Eligibility, and Benefit Inquiry (270) from a submitter (information receiver) to an information source organization
- Health Care Coverage, Eligibility, and Benefit Information (271) from an information source organization to a submitter (information receiver)

The eligibility transaction sets are designed to be flexible enough to encompass all the information requirements of the various entities. These entities may include:

- insurance companies
- health maintenance organizations (HMOs)
- preferred provider organizations (PPOs)
- health care purchasers (i.e., employers)
- professional review organizations (PROs)
- social worker organizations
- health care providers (e.g., physicians, hospitals, laboratories)
- third-party administrators (TPAs)
- health care vendors (e.g., practice management vendors, billing services)
- service bureaus (VANs or VABs)
- government agencies such as Medicare, Medicaid, and Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)

Some submitters do not have ready access to enough information to generate an inquiry to a payer. An outside lab or pharmacy providing services to an institution may need to send an inquiry to the institutional provider to obtain enough information to identify to which payer a health care eligibility or benefit inquiry should be routed. Because of this type of situation, a 270 may be originated by a provider and sent to another provider, if the inquiry is supported by the receiving provider.

1.3.2 Basic Concepts (Definitions)

Information Source (2000A loop)

The information source is the entity who has the answer to the questions being asked in a 270 Eligibility or Benefit transaction. The information source is typically the insurer, or payer. In a managed care environment, the information source could possibly be a primary care physician or gateway provider. Regardless of the information source's actual role, they are the entity who maintains the information regarding the patient's coverage. The information source is not a clearing house, value added network or other intermediary, even if they hold the data for the true information source. The information source's role in the transaction is identified in the Information Source Name segment (2100A loop NM1).

Information Receiver (2000B loop)

The information receiver is the entity who is asking the questions in a 270 Eligibility or Benefit transaction. The information receiver is typically the medical service provider (e.g., physician, hospital, laboratory, etc.). The information receiver could also be another insurer or payer when they are attempting to verify other in-

surance coverage for their members. The information receiver could also be an employer inquiring on coverage of an employee. The information receiver's role in the transaction is identified in the Information Receiver Name segment (2100B NM1).

Subscriber (2000C loop)

The subscriber is a person who can be uniquely identified to an information source, traditionally referred to as a member. The subscriber may or may not be the patient. See definition of patient below for further detail.

Dependent (2000D loop)

The dependent is a person who cannot be uniquely identified to an information source, but can be identified by an information source when associated with a subscriber. See definition of patient below for further detail.

Patient

There is no HL loop dedicated to patient, rather, the patient can be either the subscriber or the dependent. Different types of information sources identify patients in different manners depending upon how their eligibility system is structured. There are two common approaches for the identification of patients by an information source.

The first approach is to assign each member of the family (and plan) a unique ID number. This number can be used to identify and access that individual's information independent of whether he or she is a child, spouse, or the actual subscriber to the plan. In this approach, the patient will be identified at the subscriber hierarchical level because a unique ID number exists to access eligibility information for this individual.

The second approach is either to assign the actual member or contract holder (the true subscriber) a unique ID number or utilize an existing number of theirs (such as Social Security Number or Employee Identification Number). This number is entered into the eligibility system. Any related spouse, children, or dependents are identified through the subscriber's identification number and have no unique identification number of their own. In this approach, the subscriber would be identified at the subscriber level (2000C loop) and the actual patient (spouse, child, etc.) would be identified at the dependent level (2000D loop) inside the subscriber (2000C) loop.

1.3.3 Business Uses

Batch and Real Time Definitions

Within telecommunications, there are multiple methods used for sending and receiving business transactions. Frequently, different methods involve different timings. Two methods applicable for EDI transactions are batch and real time. The 270/271 Health Care Eligibility Benefit Inquiry and Response transactions can be used in either a batch mode or in a real time mode.

Batch
When transactions are used in batch mode, they are typically grouped together in large quantities and processed en-masse. Typically, the results of a transaction

that is processed in a batch mode would be completed for the next business day if it has been received by a predetermined cut off time.

Important: When in batch mode, the 997 Functional Acknowledgment transaction must be returned as quickly as possible to acknowledge that the receiver has or has not successfully received the batch transaction. In addition, the TA1 segment must be supported for interchange level errors (see section A.1.5.1 for details).

If the transaction set is to be used in a batch mode, the Information Receiver sends the 270 to the Information Source (typically through a switch) but does not remain connected while the Information Source processes the transactions. The Information Source creates a 271 for the Information Receiver off-line. The Information Receiver typically reconnects at a later time (the amount of time is determined by the information source or switch) and picks up the 271. It is required that the 270 transaction contains no more than ninety-nine patient requests when using the transaction in a batch mode (see below for the exception). Each patient is defined as either, one subscriber loop if the member is the patient, or one dependent loop if the dependent is the patient. In a batch mode, it is possible to have more than one dependent loop for each subscriber loop. In this case, each dependent loop counts as one patient.

Real Time

Transactions that are used in a real time mode typically are those that require an immediate response. In a real time mode, the sender sends a request transaction to the receiver, either directly or through a switch (clearinghouse), and remains connected while the receiver processes the transaction and returns a response transaction to the original sender. Typically, response times range from a few seconds to around thirty seconds, and should not exceed one minute.

Important: When in real time mode, the receiver must send a response of either the response transaction, a 997 Functional Acknowledgment, or a TA1 segment (for details on the TA1 segment, see section A.1.5.1).

If the transaction set is to be used in a real time mode, the Information Receiver sends the 270 transaction through some means of telecommunication (e.g. Async., TCP/IP, LU6.2, etc.) to the Information Source (typically through a switch - see section 1.4.2) and remains connected while the Information Source processes the transaction and returns a 271 to the Information Receiver. It is required that the 270 transaction contain only one patient request when using the transaction in a real time mode (see below for the exception). One patient is defined as either, one subscriber loop if the member is the patient, or one dependent loop if the dependent is the patient.

Although it is not recommended, if the number of patients is to be greater than one for real time mode or greater than ninety-nine for batch mode, the trading partners (the Information Source, the Information Receiver and the switch the transaction is routed through, if there is one involved) must all agree to exceed the number of recommended patient requests and agree to a reasonable limit.

In the event the Information Receiver exceeds the maximum number of patient requests allowed, two possible scenarios arise. First, if the processor of the transaction (either the switch or the Information Source) detects the maximum has been exceeded, a 271 with a AAA segment with element AAA03 containing a code value “04" (Authorized Quantity Exceeded) will be issued. If this has been detected by a switch, use the AAA segment in the Information Source Level (Loop 2000A). If this has been detected by an Information Source, use the AAA segment in the Information Source Name loop (Loop 2100A). Second, the proces-

sor's system may actually fail, in which case it may not be possible to send any message back and trading partners should be aware of this possibility.

If trading partners are going to engage in both real time and batch eligibility, it is recommended that they identify the method they are using. One suggested way of identifying this is by using different identifiers for real time and batch in GS02 (Application Sender's Code) for the 270 transaction. A second suggested way is to add an extra letter to the identifier in GS02 (Application Sender's Code) for the 270 transaction, such as "B" for batch and "R" for real time. Regardless of the methodology used, this will avoid the problems associated with batch eligibility transactions getting into a real time processing environment and vice versa.

1.3.4 Supported Business Functions

The 270 transaction set is used to inquire about health care eligibility or benefit information associated with a subscriber or dependent under the subscriber's payer and group. The specific information detail requirements and any type of health care eligibility, benefit inquiry or reply message is established by the business relationship between the transaction set's submitter and recipient organization. The detail of the health care eligibility or benefit information being requested by the inquiry submitter from the information source organization is identified in the Eligibility or Benefit Inquiry (EQ) data segment. To complete the detail of the eligibility request message, the submitter may send additional data segment information within the 270 transaction sets at the subscriber and dependent levels.

An example of the overall structure of the 270 transaction set is:

Information Source (Loop 2000A)
Information Receiver (Loop 2000B)
Subscriber (Loop 2000C)
Eligibility or Benefit Inquiry
Subscriber (Loop 2000C)
Dependent (Loop 2000D)
Eligibility or Benefit Inquiry
Eligibility or Benefit Inquiry
Information Receiver (Loop 2000B)
Subscriber (Loop 2000C)
Eligibility or Benefit Inquiry
Information Source (Loop 2000A)
Information Receiver (Loop 2000B)
Subscriber (Loop 2000C)
Eligibility or Benefit Inquiry
Subscriber (Loop 2000C)
Dependent (Loop 2000D)
Eligibility or Benefit Inquiry

The corresponding 271 response follows the same structure displayed above, with the Eligibility or Benefit Information replacing the Eligibility or Benefit Inquiry.

Requesting Information (270)

The following examples illustrate the business functions that the 270 supports. The transaction set is not limited to these examples.

General Request Example

Submitter Type	Payer/Plan Benefits Requested
All Provider Types	All Medical/Surgical Benefits and Coverage Conditions

Categorical Request Example

Submitter Type	Payer/Plan Benefits Requested
Specific Provider type	All Benefits Pertinent to Provider Type

Specific Request Examples

Submitter Type	Payer/Plan Benefits Requested
Ambulatory Surgery Center	Hernia Repair
D.M.E	Wheelchair Rental
Dentist	Bonding
Free Standing Lab	Diagnostic Lab Service
Home Health	Nursing Visits
Hospital	Pre-Admission Testing
Hospital	Detoxification Services
Hospital	Psychiatric Treatment
Hospital	O.P. Surgery
Nursing Home	Physical Therapy Services
Other Allied Health Providers	Occupational Therapy
Pharmacy	Prescription Drugs
Physician	Well Baby Coverage
Physician	Hospital Visits

Reply Information (271)

The eligibility or benefit reply information from the information source organization (i.e., payer or employer) is contained in the 271 in an Eligibility or Benefit Information (EB) data segment. The information source can also return other information about eligibility and benefits based on its business agreement with the inquiry submitter and available information that it may be able to provide.

The content of the Health Care Coverage, Eligibility, and Benefit Information transaction set varies, depending on the level of data made available by the information source organization.

Note to receivers of 271 transactions: Due to the varying level of detail that can be returned in the 271, it is necessary to design your system to receive all of the data segments and data elements identified as used or situational, and account for the number of times a data segment can repeat.

General Requests

- eligibility status (i.e., active or not active in the plan)
- maximum benefits (policy limits)
- exclusions
- in-plan/out-of-plan benefits
- C.O.B information
- deductible
- co-pays

Specific Requests

- procedure coverage dates
- procedure coverage maximum amount(s) allowed
- deductible amount(s)
- remaining deductible amount(s)
- co-insurance amount(s)
- co-pay amount(s)
- coverage limitation percentage
- patient responsibility amount(s)
- non-covered amount(s)

The Health Care Eligibility transaction sets are designed to satisfy the needs of a simple eligibility status inquiry (is the subscriber/dependent eligible?) or a request for more complex benefit amounts, co-insurance, co-pays, deductibles, exclusions, and limitations related to a specific procedure. To support this broad range of health care eligibility or benefit inquiry needs, the transaction sets can be viewed as a cone of information requirements and responses to support the submitting and receiving organizations' business needs.

As more complex health care eligibility or benefit information is requested from the recipient or organization, the 270 transaction set submitter may need to supply more detailed information in the request, and the recipient may be expected to return more information in the 271 transaction set reply. The specific information detail requirements and any type of health care eligibility or benefit inquiry or reply message is established by the business relationship between the transaction sets submitter and recipient organization.

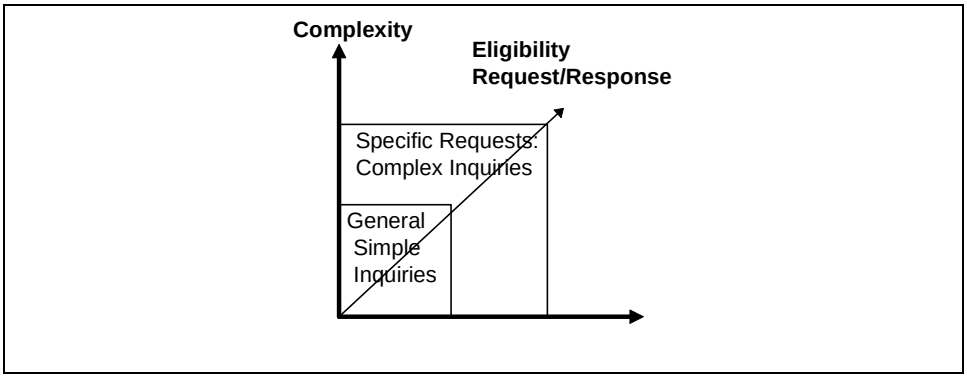


Figure 1. Information Requirements

Unsupported Business Functions

The following business functions are not intended to be supported under the 270/271 transaction sets:

- authorization requirements
- certification requirements
- utilization management/review requirements

These functions are supported by the Health Care Services Review (ASC X12 278) transaction set developed and supported by X12N/TG2/WG10, the Health Care Services Review WG.

1.3.5 Loop Usage

Loop usage within ASC X12 transactions and their implementation guides can be confusing. Care must be used to read the loop requirements in terms of the context or location within the transaction.

The usage designator of a loop's beginning segment indicates the usage of the loop. Segments within a loop can not be sent without the beginning segment of that loop.

- If the first segment is Required, the loop must occur at least once unless it is nested in a loop that is not being used. A note on the Required first segment of a nested loop will indicate dependency on the higher level loop.
- If the first segment is Situational, there will be a Segment Note addressing use of the loop. Any required segments in loops beginning with a Situational segment only occur when the loop is used. Similarly, nested loops only occur when the higher level loop is used.

1.3.6 Information Linkage

Real Time Linkage

The 270 request transaction has several methods of providing linkage to the 271 response transaction when the transaction is being processed in Real Time (see Section 1.3.3).

Information Receiver

- BHT03 - Submitter Transaction Identifier. This is used to identify the transaction at a high level. This is particularly useful in reconciling 271 reject transactions that may not contain all of the HL Loops. This information is required for the information receiver if using the transaction in Real Time and the receiver of the 270 transaction (whether it is a clearinghouse or information source) must return it in the 271 BHT03.
- TRN segments in either Loop 2000C or Loop 2000D, whichever is the patient. The information receiver may create one occurrence of the TRN segment at the lower of these levels. These segments are optional for the information receiver, however if the information source receives them, they must be returned in the 271 response transaction.

- Patient Account Number. A patient account number may be entered in REF02 of a REF segment (with REF01 being EJ) in either Loop 2100C or Loop 2100D, whichever is the patient. This information is optional for the information receiver, however if the information source receives the patient account number, they must return it in the 271 response transaction.

Information Source

- TRN segments in the 271 response transaction in either Loop 2000C or Loop 2000D, whichever is the patient. The information source may create one occurrence of the TRN segment at the lower of these levels. This segment is optional for the information source, however, this gives the information source a mechanism to pass a transaction reference number to the information receiver to use if there is a need to follow up on the transaction.

Clearinghouse

- BHT03 - Submitter Transaction Identifier. This is used to identify the transaction at a high level. This is particularly useful in reconciling 271 reject transactions that may not contain all of the HL Loops. This information is required for the clearinghouse if using the transaction in Real Time and the receiver of the 270 transaction (whether it is a clearinghouse or information source) must return it in the 271 BHT03.
- TRN segments in either Loop 2000C or Loop 2000D, whichever is the patient. A clearinghouse may create one occurrence of the TRN segment at the lower of these levels. These segments are optional for a clearinghouse however if the information source receives them, they must be returned in the 271 response transaction. In the event that the 270 transaction passes through more than one clearinghouse, the second (and subsequent) clearinghouse may choose one of the following options. Option One: If the second or subsequent clearinghouse needs to assign their own TRN segment they may replace the received TRN segment belonging to the sending clearinghouse with their own TRN segment. Upon returning a 271 response to the sending clearinghouse, they must remove their TRN segment and replace it with the sending clearinghouses TRN segment. Identification of whose TRN segment is whose can be accomplished by utilizing TRN03, which is required for clearinghouses. If the clearinghouse intends on returning their TRN segment in the 271 response to the information receiver, they must convert the value in TRN01 to “1". Option Two: If the second or subsequent clearinghouse does not need to assign their own TRN segment, they should merely pass all TRN segments received in the 270 transaction and pass all TRN segments received in the 271 response transaction.

Batch Linkage

Given the nature of batch processing which may or may not respond to each of the requests in the same batch response, the 270 request transaction has fewer methods of providing linkage to the 271 response transaction when the transactions are being processed in Batch (see Section 1.3.3).

Information Receiver

- TRN segments in either Loop 2000C or Loop 2000D, whichever is the patient. The information receiver may create one occurrence of the TRN segment at

the lower of these levels. These segments are optional for the information receiver, however if the information source receives them, they must be returned in the 271 response transaction.

- Patient Account Number. A patient account number may be entered in REF02 of a REF segment (with REF01 being EJ) in either Loop 2100C or Loop 2100D, whichever is the patient. This information is optional for the information receiver, however if the information source receives the patient account number, they must return it in the 271 response transaction.

Information Source

- TRN segments in the 271 response transaction in either Loop 2000C or Loop 2000D, whichever is the patient. The information source may create one occurrence of the TRN segment at the lower of these levels. This segment is optional for the information source, however, this gives the information source a mechanism to pass a transaction reference number to the information receiver to use if there is a need to follow up on the transaction.

1.3.7 HIPAA Compliant Use of the 270/271 Transaction Set

The ANSI ASC X12N Implementation Guideline for the Health Care Eligibility Benefit Inquiry and Response 270/271 transaction set contains a super set of data segments, elements and codes which represent its full functionality. This super set covers a great number of business scenarios and does not necessarily represent the business needs of an individual provider, payor or other trading partner involved in the use of the 270/271. The super set identifies the framework an information source (typically a payor), can utilize. HIPAA requires information sources to support an eligibility transaction, either directly or through a clearinghouse. This guide also identifies the minimum an information source or clearinghouse is required to support in order to offer a compliant 270/271 transaction.

Identification of the person being inquired about can be found in Section 1.3.8 Search Options.

Minimum requirements for HIPAA compliance

270

An information source must support a generic request for Eligibility. This is accomplished by submitting a Service Type Code of “30" (Health Benefit Plan Coverage) in the ”EQ" loop of the transaction.

271

An information source must respond with either an acknowledgment that the individual has active or inactive coverage or that the individual was not found in their system. The response will be for the date the transaction is processed, unless a specific date (prior, current or future) was used from the DTP of the EQ loop, (prior dates are needed for Medicaid inquiries, so providers can determine if a patient’s application for state medical assistance has been processed, claims can not be submitted until the benefit has been activated, which can be retroactive for qualifying recipients).

What this equates to is, “Yes, the patient is an eligible member today”. This may or may not meet the business needs of an information source, with the idea being to replace the need to have a provider’s office make a phone call to the payor to find out what the status of a patient’s insurance is.

The 271 transaction is designed to report a great deal more than “Yes, the patient is eligible today”. Some of the items that should be returned if the conditions apply are: Co-payment, Co-insurance, Deductible amounts, Eligibility Beginning and Ending Dates, allowing for dates of Service other than the current date and information about the Primary Care Provider. Additionally, specific service types and their related information can also be returned.

The 271 response can get as elaborate as identifying what days of the week a member can have a service performed and where, the number of benefits they are allowed to have and how many of them they have remaining, whether the benefit conditions apply to “in” or “out” of network, etc. Anything that is identified as situational in the 271 could possibly be returned, this is the super set. The Implementation Guide states that receivers of the 271 transaction need to “design their system to receive all of the data segments and data elements identified as used or situational, and account for the number of times a data segment can repeat.” This allows the information source the flexibility to send back relevant information without the receiver having to reprogram their system for each different information source.

Just as the 271 response can be as elaborate as the information source wishes to return, the 270 request can also be very explicit. A provider could send a 270 request asking whether a particular patient is eligible for a particular procedure with a particular diagnosis code, identify who the provider of the service will be and even identify when and where the requested service will be performed. An information source is not required to generate an explicit response to an explicit request if their system is not capable of handling such requests. However, the more information an information source can provide the information receiver regarding specific questions, the more both parties will be able to reduce phone calls and long interruptions. The information source is required to at least respond with the minimum compliant response (“Yes, the patient is eligible today” or “No, the patient is not eligible today”) and may not reject the transaction merely because they cannot process an explicit request. The information source is also required to return any information supplied in the 270 request that was used to determine the 271 response. Examples of such information are, but not limited to, service type codes, procedure codes, diagnosis codes, facility type codes, dates and identification numbers. Willing trading partners are allowed to use any portion or all of the 270/271 super set, so long as they support the minimum data set, but are not allowed to add to or change it in order to remain compliant under HIPAA.

1.3.8 Search Options

Unlike many other X12 transactions, the 270 transaction has the built in flexibility of allowing a user to enter whatever patient information they have on hand to identify them to an information source. Obviously the more information that can be provided, the more likely the information source will find a match in their system. The developers of this implementation guideline have defined a maximum data set that an information source may require and identified further elements the information source may use if they are provided. As noted in section 1.3.6, the patient may be identified in either loop 2100C or 2100D.

Required Search Options

If the patient is the subscriber, the maximum data elements that can be required by an information source to identify a patient in loop 2100C are:

Patient's Member ID (or the HIPAA Unique Patient Identifier once mandated for use)

Patient's First Name

Patient's Last Name

Patient's Date of Birth

If all four of these elements are present the information source must generate a response if the patient is in their database. All information sources are required to support the above search option.

If the patient is a dependent of a subscriber, the maximum data elements that can be required by an information source to identify a patient in loop 2100C and 2100D are:

Loop 2100C

Subscriber's Member ID (or the HIPAA Unique Patient Identifier once mandated for use)

Loop 2100D

Patient's First Name

Patient's Last Name

Patient's Date of Birth

If all four of these elements are present the information source must generate a response if the patient is in their database. All information sources are required to support the above search option if their system does not have unique Member Identifiers assigned to dependents.

Alternate Search Options

In the absence of all of the above pieces of information, such as in an emergency situation or if the patient has forgotten to bring their identification card, a 270 may be sent with as many of the above pieces of data that are available as well as any of the other items identified in the transaction (such as Social Security Number, subscriber's name when the patient is not the subscriber, relationship to insured). The information source should attempt to look up the patient if there is a reasonable amount of information present. An information source may outline additional search options available in their trading partner agreement, however under no circumstances may they require the use of a search option that differs from the ones outlined above.

Insufficient Identifying Elements

In the event that insufficient identifying elements are sent to the information source, the information source will return a 271 identifying the missing data elements in a AAA segment.

Multiple Matches

In the event that multiple matches are found in the information source's database (this should be due only to utilizing a search option other than the required search option), it is recommended that the information source should not return all the matches found. In this case, the information source should return a 271 identifying duplicates found in a AAA segment and if possible in another AAA segment , identifying the missing data elements necessary to provide an exact match.

1.3.9 Rejected Transactions

A 271 Eligibility, Coverage or Benefit Information response transaction must contain at least one EB (Eligibility or Benefit Information) segment or one AAA (Request Validation) segment. This is assuming that the 270 Eligibility, Coverage or Benefit Inquiry has passed syntax error checking without any errors and has not been identified as rejected in a 997 Functional Acknowledgment.

The AAA Request Validation segment is used to identify why an EB Eligibility or Benefit Information segment has not been generated or in essence, why the 270 Eligibility, Coverage or Benefit Inquiry has been rejected. Typically an AAA segment is generated as a result of either an error in the data being detected (e.g. Missing Subscriber ID) or no matching information in the database (e.g. Subscriber Not Found). The difference is subtle, but they generate different types of messages. If data is missing or invalid, it must be corrected and a new transaction must be generated. If an entity is not found in the database however, it could mean one of two things. The first would be that the Information Receiver should review what was submitted to verify that it was correct and if it was incorrect take the necessary steps to correct and resubmit the transactions. The second would be, if it is determined that the data was correct, the entity is not associated with the Information Source or switch processing the transaction and a definitive answer has been generated. One other use of the AAA segment is to identify a problem with the processing system itself (e.g. the Information Source's system is down). In this case, validation of data may or may not have taken place, so the assumption is made that the data is correct (AAA01 would be "Y" since it cannot point out where the error is), but the transaction will likely have to be resent (as determined by AAA04).

There are three elements that are used in the AAA segment. AAA01 is a Yes/No indicator (identifies if the data content was valid). AAA02 is not used. AAA03 is a Reject Reason Code (identifies why the transaction did not generate an EB segment). AAA04 is a Follow-up Action Code (identifies what further action should be taken).

AAA01 is used to indicate if errors were detected with the data or the transaction as a whole. A "Y" indicates that no data errors were detected and the transaction was processed as far as it could go. An "N" indicates that errors were detected in the data and corrective action is needed. The reason AAA01 would have a "Y" in the event there is a system problem is because no errors were detected in the transaction itself.

AAA03 is used to indicate why an EB segment was not generated. This is in essence an error code.

AAA04 is used to indicate what action, if any, the Information Receiver should take.

1.3.10 Disclaimers Within the Transactions

The developers of this Implementation Guideline strongly discourage the transmission of a disclaimer as a part of the transaction. Any disclaimers necessary should be outlined in the agreement between trading partners. Under no circumstances should there be more than one disclaimer segment returned per individual response.

1.4 Information Flows

Following are several scenarios where response transactions are exchanged by trading partners in different environments. The roles vary from direct connections, to connecting through communications services like VANS or other intermediaries. Requesters will operate in a variety of application environments. The following scenarios show a variety of environments using a hospital and a small physician's practice as role players.

1.4.1 Basic Information Flow

The basic flow is for a requester (usually a provider) to ask a responder (usually a payer) about health care coverage eligibility and associated benefits. The requester is normally asking about one individual, who may be the dependent of a health plan subscriber. Sometimes the responder is a third party administrator, or a Utilization Review Organization, or a self-paying employer. However, in all cases the basic flow is the same — a request sent and a response received.

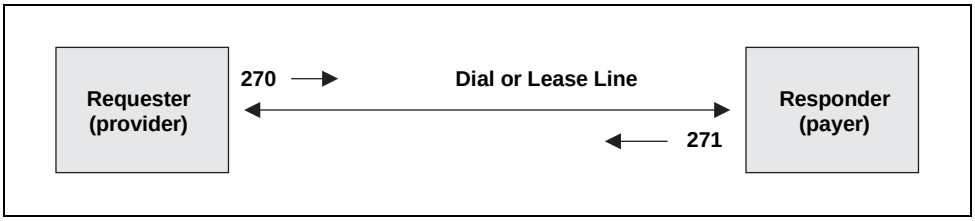


Figure 2. Basic Information Flow

1.4.2 Intermediaries

A more complicated flow is from a requester (provider) to a switch service and from the switch service to the responder (payer). The requester has an indirect link to a variety of responders via a transaction switch service. The requester has a dial-up, or leased line, or a private virtual circuit to the switch, and the switch usually has a leased line to the responder. The switch may be independent or owned by a payer.

1.4.3 Multiple Intermediaries

In some business relationships, the switch will provide access to all payers for a provider, but may not have a direct connection with all payers. The switch may have a relationship with another switch who does have a direct connection with some payers. In this case, Switch "A" will pass the message to Switch "B" to route the transaction to the responder.

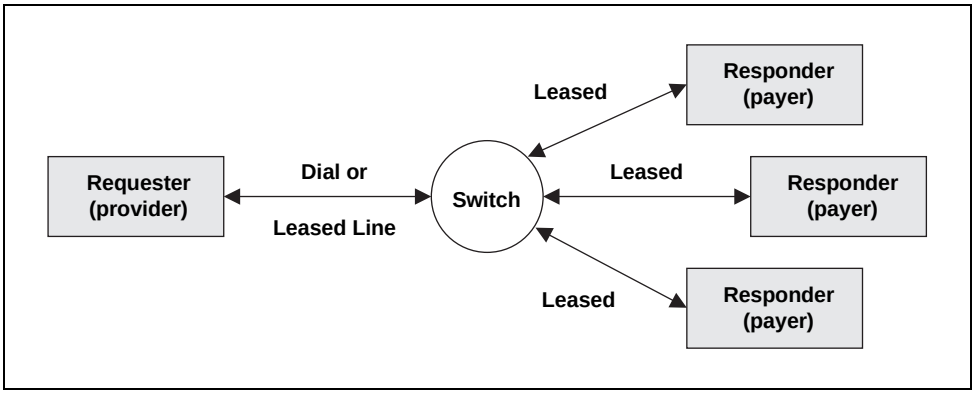


Figure 3. Intermediaries

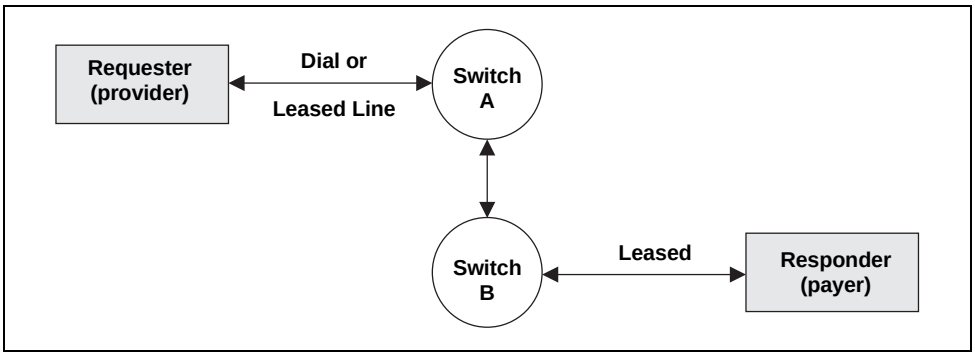


Figure 4. Multiple Intermediaries

1.4.4 Multiple Responders

In some instances, the requester will query a responder, who in turn will also query a responder for additional information. An example of this situation would be when the first responder is a Third Party Administrator (TPA), and they in turn may query an employer or a payer to ensure that the patient or subscriber is still actively enrolled. When returning the second responder's transaction to the requester, the TPA may add information to the response. Another example might be when the first responder is a payer who knows that there may be a third party liability payer; they might first query the TPL before responding to the requester.

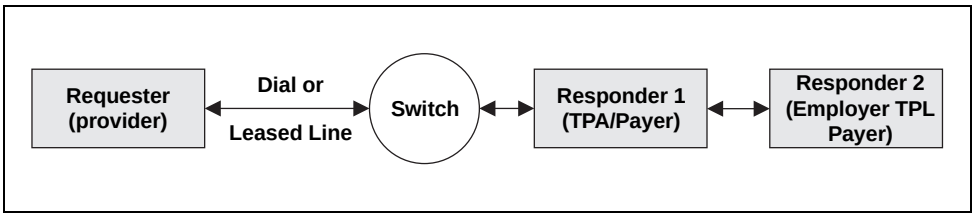


Figure 5. Multiple Responders

1.4.5 Value Added Service Organizations

With the rising need for information exchange between many organizations within the health care community, there are emerging service organizations that are enabling communication for all members of the community. Because there are many different ways to communicate with the various players in health care, service organizations will normalize communication solutions, data requirements, and transactions formats for their business partners. In these situations, the service organization will often need to open the transactions to reformat them or add needed information. In some cases, these Third Parties will perform database look-ups to determine what formats and additional information is required. They will then direct the transactions on to the appropriate responder or requester.

There can be other layers of complexity here, when switches might also be involved.

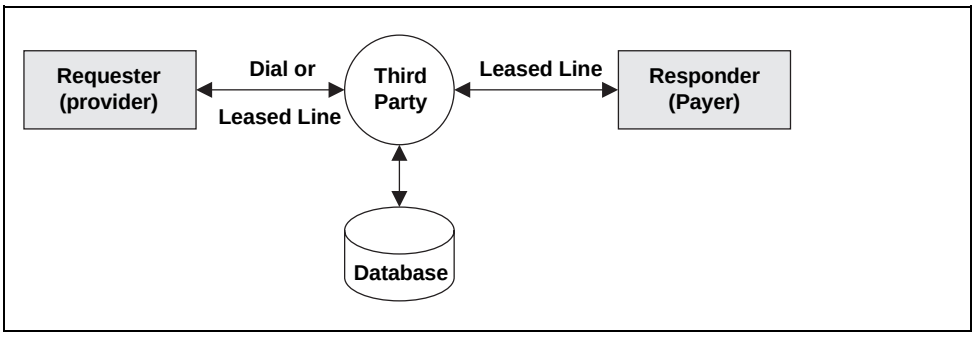


Figure 6. Value Added Service Organizations

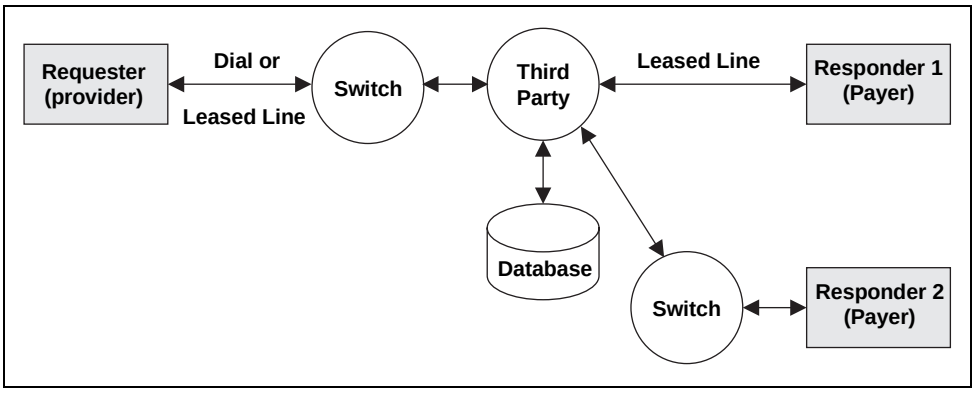


Figure 7. Value Added Service Organizations with Switches

1.4.6 Complex Requester Environments

There are also considerations for complex requester environments for transaction routing. Hospitals and Integrated Health Networks (IHN) are good examples of this need. The hospital or IHN may have many systems within its enterprise or environment from which it receives requests. It then delivers these requests to a service organization or payers. For example, an IHN may include a hospital, a free standing clinic, a reference lab, and an x-ray department each having its own information system, but a common interface engine to the payers or VAN or service organization. In some cases, this interface engine may also be perform-

ing data and communication transformations, for example taking HL7 transactions and converting them to X12 transactions.

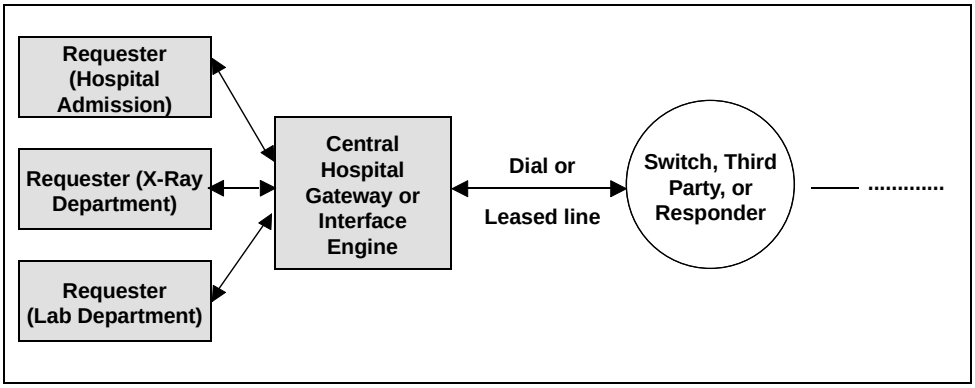


Figure 8. Complex Requester Environments

2 Data Overview

2.1 Overall Data Architecture

NOTE
See Appendix A, ASC X12 Nomenclature, for a complete review of the message structure (transactions set) including descriptions of the segments, data elements, etc.

2.2 Data Use by Business Use

The 270/271 transactions are divided into two levels, or tables. See Section 3, Transaction Set, for a description of the transaction sets.

The Header Level, Table 1, contains transaction structure information.

The Detail Level, Table 2, contains specific information about the insurer, requester of information, insured, and dependents. This implementation uses four different ways to use the segments in table 2. Each HL is assigned a number identifying its purpose.

- Loop 2000A (information source) contains information typically about the insurer/payer.
- Loop 2000B (information receiver) contains information typically about the medical service provider. (e.g., physician, hospital, laboratory, etc.).
- Loop 2000C (insured) contains information about the insured member (who may or may not be the patient).
- Loop 2000D (dependent) contains information about dependents of an insured member.

3 Transaction Sets

NOTE
See Appendix A, ASC X12 Nomenclature, for a review of transaction set structure, including descriptions of segments, data elements, levels, and loops.

3.1 Presentation Examples

The ASC X12 standards are generic. For example, multiple trading communities use the same PER segment to specify administrative communication contacts. Each community decides which elements to use and which code values in those elements are applicable. This implementation guide uses a format that depicts both the generalized standard and the trading community-specific implementation.

The transaction set detail is comprised of two main sections with subsections within the main sections.

Transaction Set Listing

- Implementation
- Standard

Segment Detail

- Implementation
- Standard
- Diagram
- Element Summary

The examples in figures 9 through 14 define the presentation of the transaction set that follows.

The following pages provide illustrations, in the same order they appear in the guide, to describe the format.

The examples are drawn from the 835 Health Care Claim Payment/Advice Transaction Set, but all principles apply.

IMPLEMENTATION

Indicates that this section is the implementation and not the standard

835 Health Care Claim Payment/Advice

Table 1 - Header

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
53	010	ST	835 Header	R	1	
54	020	BPR	Financial Information	R	1	
60	040	TRN	Reassociation Key	R	1	
62	050	CUR	Non-US Dollars Currency	S	1	
65	060	REF	Receiver ID	S	1	
66	060	REF	Version Number	S	1	
68	070	DTM	Production Date	S	1	
			PAYER NAME			1
70	080	N1	Payer Name	R	1	
72	100	N3	Payer Address	S	1	
75	110	N4	Payer City, State, Zip	S	1	
76	120	REF	Additional Payer Reference Number	S	1	
78	130	PER	Payer Contact	S	1	
			PAYEE NAME			1
79	080	N1	Payee Name	R	1	
81	100	N3	Payee Address	S	1	
82	110	N4	Payee City, State, Zip	S	1	
84	120	REF	Payee Additional Reference Number	S	>1	

Each segment is assigned an industry specific name. Not used segments do not appear

Each loop is assigned an industry specific name

R=Required
S=Situational

Segment repeats and loop repeats reflect actual usage

Position Numbers and Segment IDs retain their X12 values

Individual segments and entire loops are repeated

Figure 9. Transaction Set Key — Implementation

STANDARD

Indicates that this section is identical to the ASC X12 standard

See Appendix A, ASC X12 Nomenclature for a complete description of the standard

835 Health Care Claim Payment/Advice

Functional Group ID: HP

This Draft Standard for Trial Use contains the format and establishes the data contents of the Health Care Claim Payment/Advice Transaction Set (835) within the context of the Electronic Data Interchange (EDI) environment. This transaction set can be used to make a payment, send an Explanation of Benefits (EOB) remittance advice, or make a payment and send an EOB remittance advice only from a health insurer to a health care provider either directly or via a financial institution.

Table 1 - Header

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
010	ST	Transaction Set Header	M	1	
020	BPR	Beginning Segment for Payment Order/Remittance Advice	M	1	
030	NTE	Note/Special Instruction	O	>1	
040	TRN	Trace	O	1	

Figure 10. Transaction Set Key — Standard

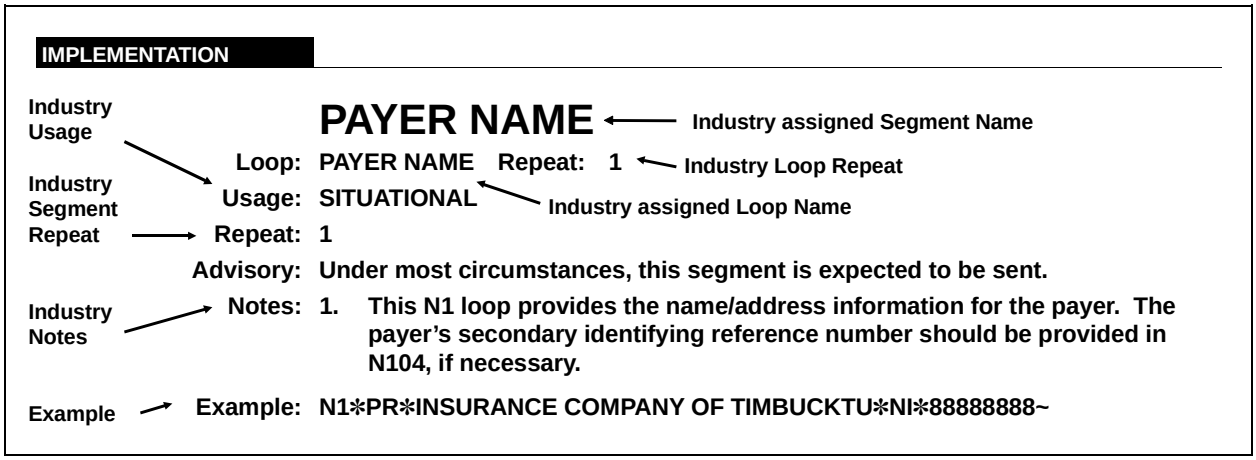


Figure 11. Segment Key — Implementation

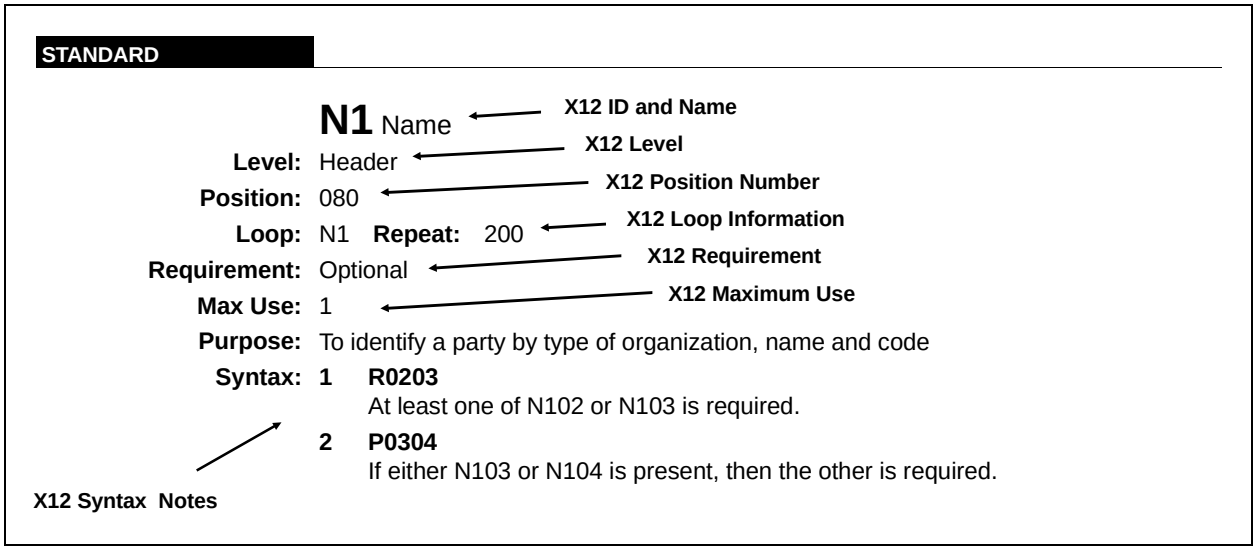


Figure 12. Segment Key — Standard

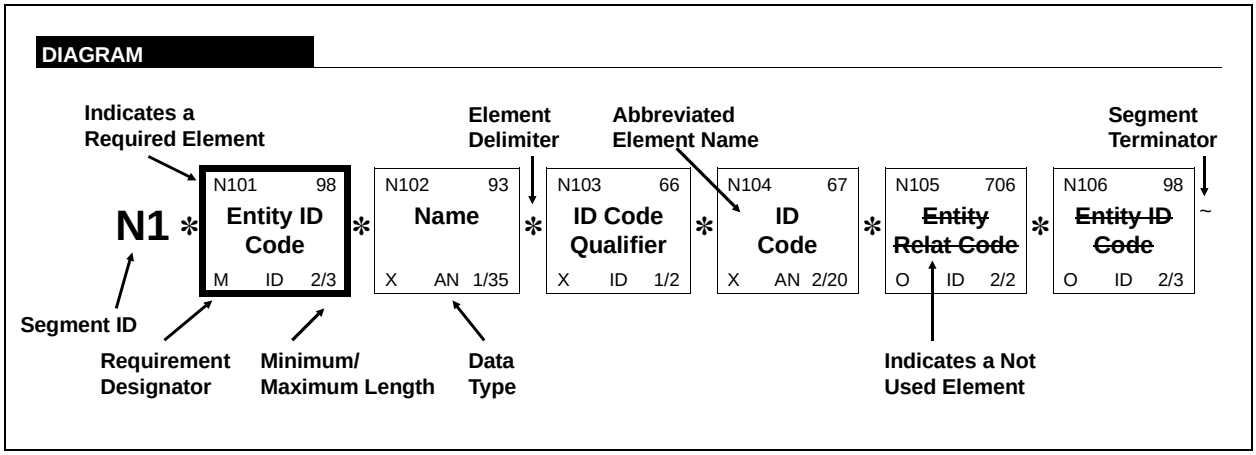
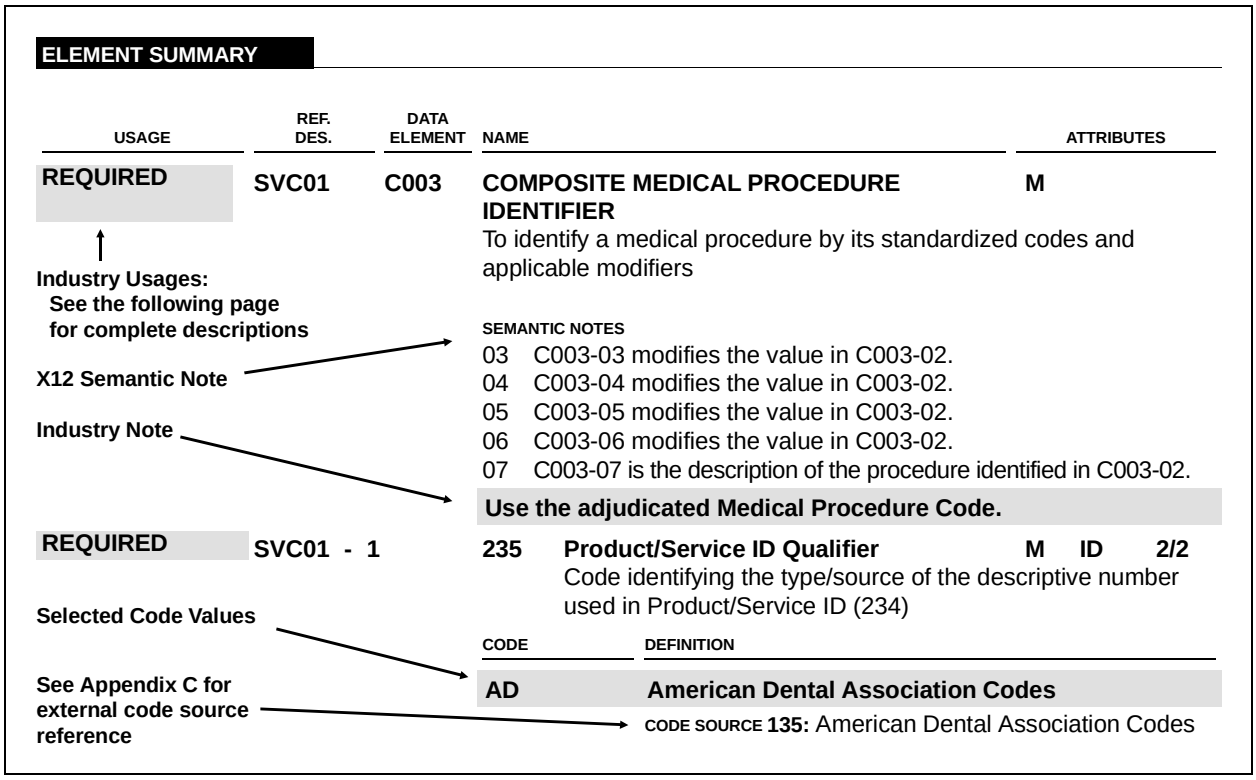


Figure 13. Segment Key — Diagram



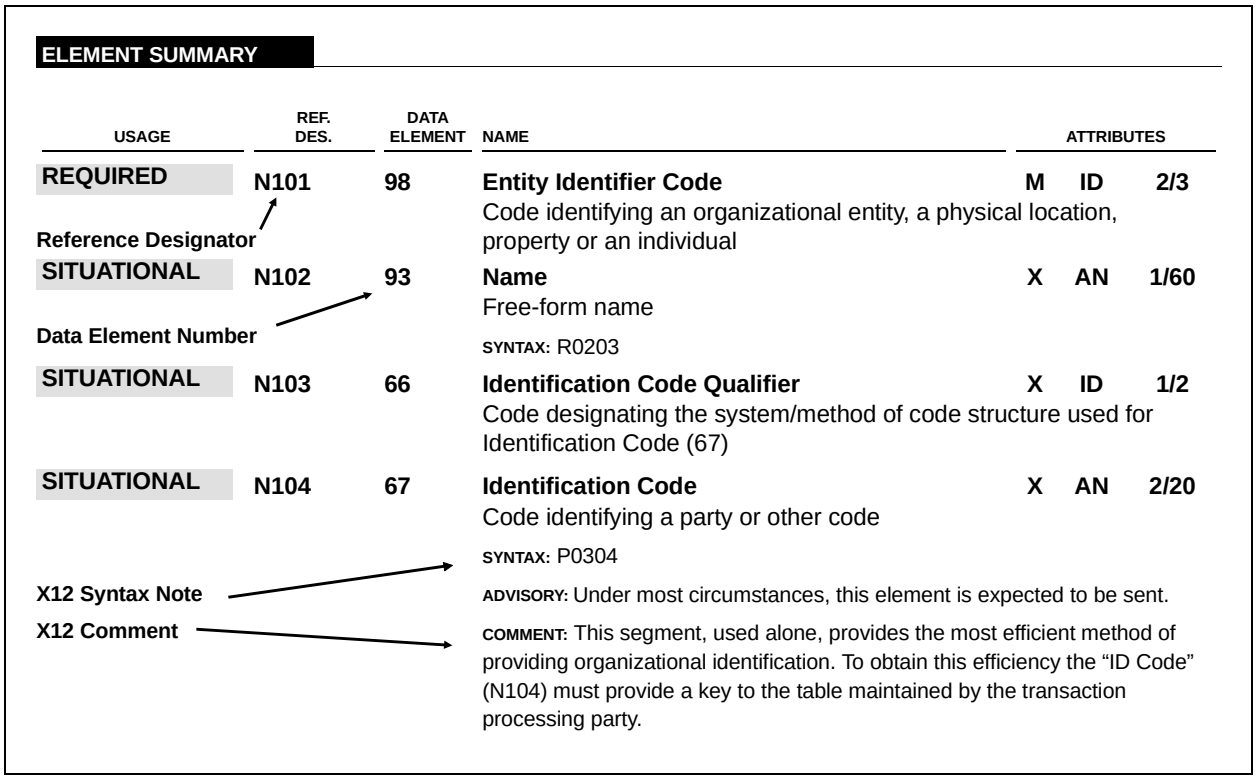


Figure 14. Segment Key — Element Summary

Industry Usages:

Required	This item must be used to be compliant with this implementation guide.
Not Used	This item should not be used when complying with this implementation guide.
Situational	The use of this item varies, depending on data content and business context. The defining rule is generally documented in a syntax or usage note attached to the item.* The item should be used whenever the situation defined in the note is true; otherwise, the item should not be used. **** NOTE*** If no rule appears in the notes, the item should be sent if the data is available to the sender.

Loop Usages:
Loop usage within ASC X12 transactions and their implementation guides can be confusing. Care must be used to read the loop requirements in terms of the context or location within the transaction. The usage designator of a loop's beginning segment indicates the usage of the loop. Segments within a loop cannot be sent without the beginning segment of that loop.

If the first segment is Required, the loop must occur at least once unless it is nested in a loop that is not being used. A note on the Required first segment of a nested loop will indicate dependency on the higher level loop.

If the first segment is Situational, there will be a Segment Note addressing use of the loop. Any required segments in loops beginning with a Situational segment only occur when the loop is used. Similarly, nested loops only occur when the higher level loop is used.

IMPLEMENTATION

270 Eligibility, Coverage or Benefit Inquiry

Table 1 - Header

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
36	010	ST	Transaction Set Header	R	1	
38	020	BHT	Beginning of Hierarchical Transaction	R	1	

Table 2 - Detail, Information Source Level

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000A INFORMATION SOURCE LEVEL			>1
41	010	HL	Information Source Level	R	1	
			LOOP ID - 2100A INFORMATION SOURCE NAME			1
44	030	NM1	Information Source Name	R	1	

Table 2 - Detail, Information Receiver Level

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000B INFORMATION RECEIVER LEVEL			>1
47	010	HL	Information Receiver Level	R	1	
			LOOP ID - 2100B INFORMATION RECEIVER NAME			1
50	030	NM1	Information Receiver Name	R	1	
54	040	REF	Information Receiver Additional Identification	S	9	
57	060	N3	Information Receiver Address	S	1	
58	070	N4	Information Receiver City/State/ZIP Code	S	1	
60	080	PER	Information Receiver Contact Information	S	3	
64	090	PRV	Information Receiver Provider Information	S	1	

Table 2 - Detail, Subscriber Level

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000C SUBSCRIBER LEVEL			>1
66	010	HL	Subscriber Level	R	1	
69	020	TRN	Subscriber Trace Number	S	2	
			LOOP ID - 2100C SUBSCRIBER NAME			1
71	030	NM1	Subscriber Name	R	1	
74	040	REF	Subscriber Additional Identification	S	9	
77	060	N3	Subscriber Address	S	1	
78	070	N4	Subscriber City/State/ZIP Code	S	1	
80	090	PRV	Provider Information	S	1	
83	100	DMG	Subscriber Demographic Information	S	1	
85	110	INS	Subscriber Relationship	S	1	

87	120	DTP	Subscriber Date	S	2	
			LOOP ID - 2110C SUBSCRIBER ELIGIBILITY OR BENEFIT INQUIRY INFORMATION			99
89	130	EQ	Subscriber Eligibility or Benefit Inquiry Information	S	1	
99	135	AMT	Subscriber Spend Down Amount	S	1	
101	170	III	Subscriber Eligibility or Benefit Additional Inquiry Information	S	10	
104	190	REF	Subscriber Additional Information	S	1	
106	200	DTP	Subscriber Eligibility/Benefit Date	S	1	

Table 2 - Detail, Dependent Level

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000D DEPENDENT LEVEL			>1
108	010	HL	Dependent Level	S	1	
112	020	TRN	Dependent Trace Number	S	2	
			LOOP ID - 2100D DEPENDENT NAME			1
114	030	NM1	Dependent Name	R	1	
116	040	REF	Dependent Additional Identification	S	9	
118	060	N3	Dependent Address	S	1	
119	070	N4	Dependent City/State/ZIP Code	S	1	
121	090	PRV	Provider Information	S	1	
124	100	DMG	Dependent Demographic Information	S	1	
126	110	INS	Dependent Relationship	S	1	
129	120	DTP	Dependent Date	S	2	
			LOOP ID - 2110D DEPENDENT ELIGIBILITY OR BENEFIT INQUIRY INFORMATION			99
131	130	EQ	Dependent Eligibility or Benefit Inquiry Information	R	1	
140	170	III	Dependent Eligibility or Benefit Additional Inquiry Information	S	10	
143	190	REF	Dependent Additional Information	S	1	
145	200	DTP	Dependent Eligibility/Benefit Date	S	1	
147	210	SE	Transaction Set Trailer	R	1	

STANDARD

270 Eligibility, Coverage or Benefit Inquiry

Functional Group ID: HS

This Draft Standard for Trial Use contains the format and establishes the data contents of the Eligibility, Coverage or Benefit Inquiry Transaction Set (270) for use within the context of an Electronic Data Interchange (EDI) environment. This transaction set can be used to inquire about the eligibility, coverages or benefits associated with a benefit plan, employer, plan sponsor, subscriber or a dependent under the subscriber's policy. The transaction set is intended to be used by all lines of insurance such as Health, Life, and Property and Casualty.

Table 1 - Header

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
010	ST	Transaction Set Header	M	1	
020	BHT	Beginning of Hierarchical Transaction	M	1	

Table 2 - Detail

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
		LOOP ID - 2000			>1
010	HL	Hierarchical Level	M	1	
020	TRN	Trace	O	9	
		LOOP ID - 2100			>1
030	NM1	Individual or Organizational Name	M	1	
040	REF	Reference Identification	O	9	
050	N2	Additional Name Information	O	1	
060	N3	Address Information	O	1	
070	N4	Geographic Location	O	1	
080	PER	Administrative Communications Contact	O	3	
090	PRV	Provider Information	O	1	
100	DMG	Demographic Information	O	1	
110	INS	Insured Benefit	O	1	
120	DTP	Date or Time or Period	O	9	
		LOOP ID - 2110			99
130	EQ	Eligibility or Benefit Inquiry	O	1	
135	AMT	Monetary Amount	O	2	
140	VEH	Vehicle Information	O	1	
150	PDR	Property Description - Real	O	1	
160	PDP	Property Description - Personal	O	1	
170	III	Information	O	10	
190	REF	Reference Identification	O	1	
200	DTP	Date or Time or Period	O	9	
210	SE	Transaction Set Trailer	M	1	

NOTE:

2/020 If the Eligibility, Coverage or Benefit Inquiry Transaction Set (270) includes a TRN segment, then the Eligibility, Coverage or Benefit Information Transaction Set (271) must return the trace number identified in the TRN segment.

IMPLEMENTATION

TRANSACTION SET HEADER

Usage: **REQUIRED**

Repeat: **1**

Notes: **1. Use this control segment to mark the start of a transaction set. One ST segment exists for every transaction set that occurs within a functional group.**

Example: **ST*270*0001~**

STANDARD

ST Transaction Set Header

Level: Header

Position: 010

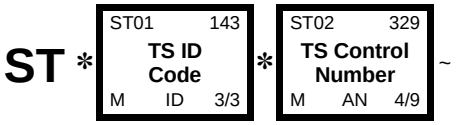
Loop: ____

Requirement: Mandatory

Max Use: 1

Purpose: To indicate the start of a transaction set and to assign a control number

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**ST01**	**143**	**Transaction Set Identifier Code** Code uniquely identifying a Transaction Set SEMANTIC: The transaction set identifier (ST01) used by the translation routines of the interchange partners to select the appropriate transaction set definition (e.g., 810 selects the Invoice Transaction Set). **Use this code to identify the transaction set ID for the transaction set that will follow the ST segment. Each X12 standard has a transaction set identifier code that is unique to that transaction set.**	**M ID 3/3**

CODE	DEFINITION
270	**Eligibility, Coverage or Benefit Inquiry**

REQUIRED	**ST02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set	**M**	**AN**	**4/9**

The transaction set control numbers in ST02 and SE02 must be identical. This unique number also aids in error resolution research. Start with the number, for example “0001", and increment from there. This number must be unique within a specific group and interchange, but can repeat in other groups and interchanges.

IMPLEMENTATION

BEGINNING OF HIERARCHICAL TRANSACTION

Usage: **REQUIRED**

Repeat: **1**

Notes: **1. Use this required segment to start the transaction set and indicate the sequence of the hierarchical levels of information that will follow in Table 2.**

Example: **BHT*0022*13*199800114000001*19980101*1400~**

Example: **BHT*0022*36**19980101*1400*RU~**

STANDARD

BHT Beginning of Hierarchical Transaction

Level: Header

Position: 020

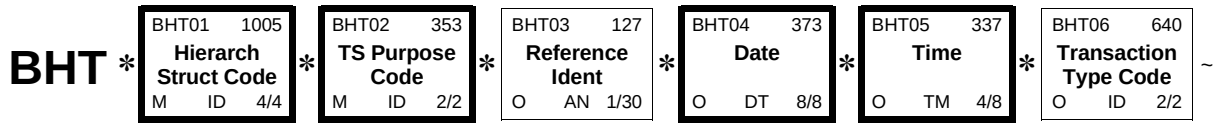
Loop: ____

Requirement: Mandatory

Max Use: 1

Purpose: To define the business hierarchical structure of the transaction set and identify the business application purpose and reference data, i.e., number, date, and time

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**BHT01**	**1005**	**Hierarchical Structure Code** Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set	**M ID 4/4**

Use this code to specify the sequence of hierarchical levels that may appear in the transaction set. This code only indicates the sequence of the levels, not the requirement that all levels be present. For example, if code "0022" is used, the dependent level may or may not be present for each subscriber.

CODE	DEFINITION
0022	**Information Source, Information Receiver, Subscriber, Dependent**

REQUIRED **BHT02** **353** **Transaction Set Purpose Code** **M ID 2/2**
Code identifying purpose of transaction set

CODE	DEFINITION
01	**Cancellation** **Use this code to cancel a previously submitted 270 transaction. Only 270 transactions that used a BHT06 code of either "RT" or "RU" can be canceled. The cancellation 270 transaction must contain the same BHT06 code as the previously submitted 270 transaction.**
13	**Request**
36	**Authority to Deduct (Reply)** **Some health plans, Medicaid in particular, limit the number of certain services allowed during a certain period of time. These services are typically deducted from the count at the time an eligibility request is sent (if there are services remaining). A positive response in a 271 not only indicates that the inquired benefit exists but that the count for this service has been reduced by one (unless a specific number of services greater than one are requested in the request). If the service is not rendered, a Cancellation 270 must be submitted (using BHT02 code "01").**

SITUATIONAL **BHT03** **127** **Reference Identification** **O AN 1/30**
Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

INDUSTRY: ***Submitter Transaction Identifier***

ADVISORY: Under most circumstances, this element is expected to be sent.

SEMANTIC: BHT03 is the number assigned by the originator to identify the transaction within the originator's business application system.

This element is required to be used if the transaction is processed in Real Time.

This element is to be used to trace the transaction from one point to the next point, such as when the transaction is passed from one clearinghouse to another clearinghouse. This identifier is to be returned in the corresponding 271 transaction's BHT03. This identifier will only be returned by the last entity to handle the 270. This identifier will not be passed through the complete life of the transaction. All recipients of 270 transactions are required to return the Submitter Transaction Identifier in their 271 response if one is submitted.

REQUIRED **BHT04** **373** **Date** **O DT 8/8**
Date expressed as CCYYMMDD

INDUSTRY: ***Transaction Set Creation Date***

SEMANTIC: BHT04 is the date the transaction was created within the business application system.

Use this date for the date the transaction set was generated.

REQUIRED **BHT05** **337** **Time** **O** **TM** **4/8**

Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99)

INDUSTRY: ***Transaction Set Creation Time***

SEMANTIC: BHT05 is the time the transaction was created within the business application system.

Use this time for the time the transaction set was generated.

SITUATIONAL **BHT06** **640** **Transaction Type Code** **O** **ID** **2/2**

Code specifying the type of transaction

Certain Medicaid programs support additional functionality for Spend Down or Medical Services Reservation. Use this code when necessary to further specify the type of transaction to a Medicaid program that supports this functionality.

CODE	DEFINITION
RT	**Spend Down** **"Spend Down" is a term used by certain Medicaid programs when a recipient must pay a predetermined amount out of his or her own pocket before full coverage benefits are applied. In order to decrement the amount the recipient must pay out of pocket, a 270 transaction must be sent in with this code.**
RU	**Medical Services Reservation** **"Medical Services Reservation" is a term used by certain Medicaid programs when a recipient is allowed a predetermined amount of a particular service. To decrement the count, a Medical Services Reservation must be sent in. In the event that the service is not rendered, an additional 270 must be sent in with a BHT02 with a code "01" to cancel the Medical Services Reservation.**

IMPLEMENTATION

INFORMATION SOURCE LEVEL

Loop: **2000A — INFORMATION SOURCE LEVEL Repeat: >1**

Usage: **REQUIRED**

Repeat: **1**

Notes:

1. **Use this segment to identify the hierarchical or entity level of information being conveyed. The HL structure allows for the efficient nesting of related occurrences of information. The developers' intent is to clearly identify the relationship of the patient to the subscriber and the subscriber to the provider.**

   Additionally, multiple subscribers and/or dependents (i.e., the patient) can be grouped together under the same provider or the information for multiple providers or information receivers can be grouped together for the same payer or information source.

2. **In a batch environment, only one Loop 2000A (Information Source) loop is to be created for each unique information source in a transaction. Each Loop 2000B (Information Receiver) loop that is subordinate to an information source is to be contained within only one Loop 2000A loop. There has been a misuse of the HL structure creating multiple Loops 2000As for the same information source. This is not the developer's intended use of the HL structure, and defeats the efficiencies that are designed into the HL structure.**

3. **An example of the overall structure of the transaction set when used in batch mode is:**

   Information Source (Loop 2000A)
   Information Receiver (Loop 2000B)
   Subscriber (Loop 2000C)
   Dependent (Loop 2000D)
   Eligibility or Benefit Inquiry
   Dependent (Loop 2000D)
   Eligibility or Benefit Inquiry
   Subscriber (Loop 2000C)
   Eligibility or Benefit Inquiry

Example: **HL*1**20*1~**

STANDARD

HL Hierarchical Level

Level: Detail

Position: 010

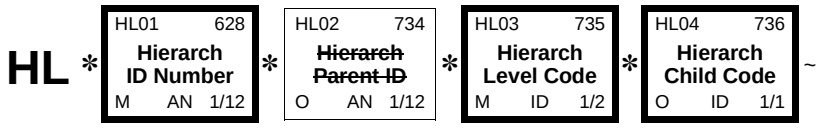
Loop: 2000 **Repeat:** >1

Requirement: Mandatory

Max Use: 1

Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure COMMENT: HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction. **Use this sequentially assigned positive number to identify each specific occurrence of an HL segment within a transaction set. It should begin with the number one and be incremented by one for each successive occurrence of the HL segment within that specific transaction set (ST through SE).** **An example of the use of the HL segment and this data element is:** **HL*1**20*1~** **NM1*PR*2*ABC INSURANCE COMPANY*****PI*842610001~**	**M AN 1/12**
NOT USED	**HL02**	**734**	**Hierarchical Parent ID Number**	**O AN 1/12**
REQUIRED	**HL03**	**735**	**Hierarchical Level Code** Code defining the characteristic of a level in a hierarchical structure COMMENT: HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information. **All data that follows an HL segment is associated with the entity identified by the level code; this association continues until the next occurrence of an HL segment.**	**M ID 1/2**

CODE	DEFINITION
20	**Information Source**

REQUIRED **HL04** **736** **Hierarchical Child Code** **O ID 1/1**

Code indicating if there are hierarchical child data segments subordinate to the level being described

COMMENT: HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

Use this code to indicate whether there are additional hierarchical levels subordinate to the current hierarchical level.

Because of the hierarchical structure, and because an additional HL always exists in this transaction, the code value in the HL04 at the Loop 2000A level should always be "1".

CODE	DEFINITION
1	**Additional Subordinate HL Data Segment in This Hierarchical Structure.**

IMPLEMENTATION

INFORMATION SOURCE NAME

Loop: **2100A — INFORMATION SOURCE NAME Repeat: 1**

Usage: **REQUIRED**

Repeat: **1**

Notes: **1. Use this NM1 loop to identify an entity by name and/or identification number. This NM1 loop is used to identify the eligibility or benefit information source, (e.g., insurance company, HMO, IPA, employer).**

Example: **NM1*PR*2*ACE INSURANCE COMPANY*****PI*87728~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 030

Loop: 2100 **Repeat:** >1

Requirement: Mandatory

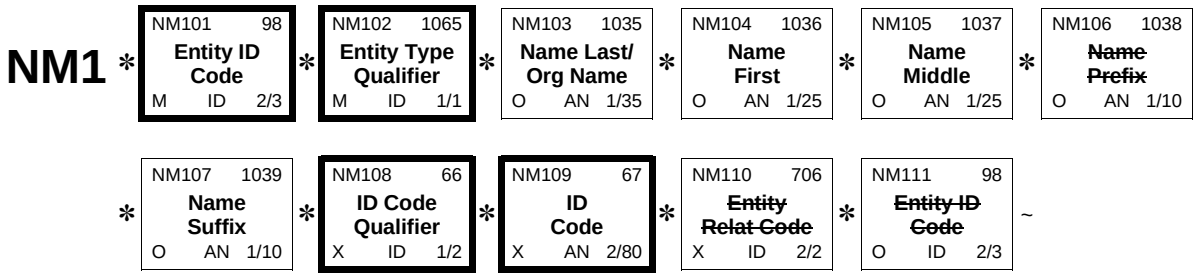
Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

Syntax: **1. P0809**
If either NM108 or NM109 is present, then the other is required.

2. C1110
If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M ID 2/3**

CODE	DEFINITION
2B	**Third-Party Administrator**
36	**Employer**

			GP **Gateway Provider**			
			P5 **Plan Sponsor**			
			PR **Payer**			
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103. **Use this code to indicate whether the entity is an individual person or an organization.** CODE / DEFINITION **1** **Person** **2** **Non-Person Entity**	**M**	**ID**	**1/1**
SITUATIONAL	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name *INDUSTRY:* ***Information Source Last or Organization Name*** **Use this name for the organization's name if the entity type qualifier is a non-person entity. Otherwise, use this name for the individual's last name. Use if name information is needed to identify the source of eligibility or benefit information.**	**O**	**AN**	**1/35**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name *INDUSTRY:* ***Information Source First Name*** **Use this name only if NM102 is "1" and information is needed to identify the source of eligibility or benefit information.**	**O**	**AN**	**1/25**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial *INDUSTRY:* ***Information Source Middle Name*** **Use this name only if NM102 is "1" and information is needed to identify the source of eligibility or benefit information.**	**O**	**AN**	**1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**AN**	**1/10**
SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name *INDUSTRY:* ***Information Source Name Suffix*** **Use this name only if NM102 is "1" and information is needed to identify the source of eligibility or benefit information.**	**O**	**AN**	**1/10**

REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809	**X**	**ID**	**1/2**

Use code value "XV" if the Information Source is a Payer and the National PlanID is mandated for use. Use code value "XX" if the information source is a provider and the HCFA National Provider Identifier is mandated for use. Otherwise one of the other appropriate code values may be used.

CODE	DEFINITION
24	**Employer's Identification Number**
46	**Electronic Transmitter Identification Number (ETIN)**
FI	**Federal Taxpayer's Identification Number**
NI	**National Association of Insurance Commissioners (NAIC) Identification**
PI	**Payor Identification**
XV	**Health Care Financing Administration National PlanID** ***Required if the National PlanID is mandated for use. Otherwise, one of the other listed codes may be used.***
	CODE SOURCE **540:** Health Care Financing Administration National PlanID
XX	**Health Care Financing Administration National Provider Identifier** ***Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.***

REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Information Source Primary Identifier*** SYNTAX: P0809	**X**	**AN**	**2/80**

Use this reference number as qualified by the preceding data element (NM108).

NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

INFORMATION RECEIVER LEVEL

Loop: **2000B — INFORMATION RECEIVER LEVEL** **Repeat:** **>1**

Usage: **REQUIRED**

Repeat: **1**

Notes:

1. **Use this segment to identify the hierarchical or entity level of information being conveyed. The HL structure allows for the efficient nesting of related occurrences of information. The developers' intent is to clearly identify the relationship of the patient to the subscriber and the subscriber to the provider.**

   Additionally, multiple subscribers and/or dependents (i.e., the patient) can be grouped together under the same provider or the information for multiple providers or information receivers can be grouped together for the same payer or information source.

2. **In a batch environment, only one Loop 2000B (Information Receiver) loop is to be created for each unique information receiver within an Loop 2000A (Information Source) loop. Each Loop 2000C (Subscriber) loop that is subordinate to an information receiver is to be contained within only one Loop 2000B loop. There has been a misuse of the HL structure creating multiple Loop 2000Bs for the same information receiver with in an information source loop. This is not the developer's intended use of the HL structure, and defeats the efficiencies that are designed into the HL structure.**

3. **An example of the overall structure of the transaction set when used in batch mode is:**

   Information Source (Loop 2000A)
   Information Receiver (Loop 2000B)
   Subscriber (Loop 2000C)
   Dependent (Loop 2000D)
   Eligibility or Benefit Inquiry
   Dependent (Loop 2000D)
   Eligibility or Benefit Inquiry
   Subscriber (Loop 2000C)
   Eligibility or Benefit Inquiry

Example: **HL*2*1*21*1~**

STANDARD

HL Hierarchical Level

Level: Detail

Position: 010

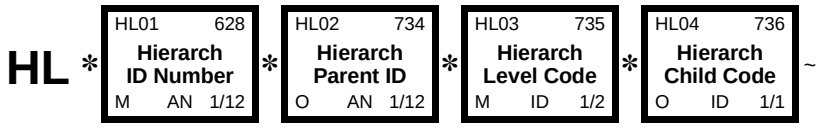
Loop: 2000 **Repeat:** >1

Requirement: Mandatory

Max Use: 1

Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure COMMENT: HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction. **Use this sequentially assigned positive number to identify each specific occurrence of an HL segment within a transaction set. It should begin with the number one and be incremented by one for each successive occurrence of the HL segment within that specific transaction set (ST through SE).** **An example of the use of the HL segment and this data element is:** **HL*1**20*1~** **NM1*PR*2*ABC INSURANCE COMPANY*****PI*842610001~** **HL*2*1*21*1~** **NM1*1P*1*JONES*MARCUS***MD*SV*0202034~**	**M AN 1/12**
REQUIRED	**HL02**	**734**	**Hierarchical Parent ID Number** Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to COMMENT: HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate. **Use this code to identify the specific hierarchical level to which this level is subordinate.**	**O AN 1/12**
REQUIRED	**HL03**	**735**	**Hierarchical Level Code** Code defining the characteristic of a level in a hierarchical structure COMMENT: HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information. **All data that follows an HL segment is associated with the entity identified by the level code; this association continues until the next occurrence of an HL segment.**	**M ID 1/2**

CODE	DEFINITION
21	**Information Receiver**

REQUIRED **HL04** **736** **Hierarchical Child Code** **O ID 1/1**

Code indicating if there are hierarchical child data segments subordinate to the level being described

COMMENT: HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

Use this code to indicate whether there are additional hierarchical levels subordinate to the current hierarchical level.

Because of the hierarchical structure, and because an additional HL always exists in this transaction, the code value in HL04 at the Loop 2000B level will always be "1".

CODE	DEFINITION
1	**Additional Subordinate HL Data Segment in This Hierarchical Structure.**

IMPLEMENTATION

INFORMATION RECEIVER NAME

Loop: **2100B — INFORMATION RECEIVER NAME** **Repeat:** **1**

Usage: **REQUIRED**

Repeat: **1**

Notes:
1. **Use this segment to identify an entity by name and/or identification number. This NM1 loop is used to identify the eligibility/benefit information receiver (e.g., provider, medical group, employer, IPA, or hospital).**

Example: **NM1*1P*1*JONES*MARCUS***MD*34*111223333~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 030

Loop: 2100 **Repeat:** >1

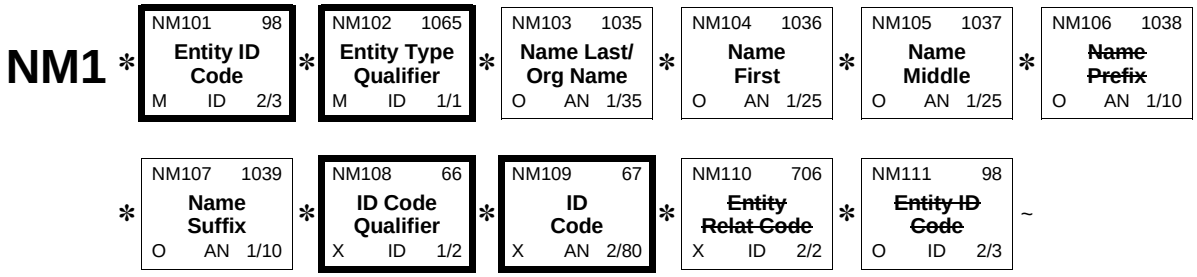
Requirement: Mandatory

Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

Syntax:
1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M ID 2/3**

CODE	DEFINITION
1P	**Provider**
2B	**Third-Party Administrator**

			36 **Employer**			
			80 **Hospital**			
			FA **Facility**			
			GP **Gateway Provider**			
			P5 **Plan Sponsor**			
			PR **Payer**			
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103. **Use this code to indicate whether the entity is an individual person or an organization.** CODE / DEFINITION **1** **Person** **2** **Non-Person Entity**	**M**	**ID**	**1/1**
SITUATIONAL	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name ***INDUSTRY:*** ***Information Receiver Last or Organization Name*** **Use this name for the organization's name if the entity type qualifier is a non-person entity. Otherwise, use this name for the individual's last name. Use if name information is needed to identify the receiver of eligibility or benefit information.**	**O**	**AN**	**1/35**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name ***INDUSTRY:*** ***Information Receiver First Name*** **Use this name only if NM102 is "1".**	**O**	**AN**	**1/25**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial ***INDUSTRY:*** ***Information Receiver Middle Name*** **Use this name only if NM102 is "1".**	**O**	**AN**	**1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**AN**	**1/10**
SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name ***INDUSTRY:*** ***Information Receiver Name Suffix*** **Use this for the suffix to an individual's name; e.g., Sr., Jr. or III.** **Use this only if NM102 is "1".**	**O**	**AN**	**1/10**

REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67)	**X**	**ID**	**1/2**

SYNTAX: P0809

Use this element to qualify the identification number submitted in NM109. This is the number that the information source associates with the information receiver. Because only one number can be submitted in NM109, the following hierarchy must be used. Additional identifiers are to be placed in the REF segment. If the National Provider ID is mandated for use, use code value "XX". Otherwise one of the other code values may be used. If another code value is used, the following hierarchy must be applied: Use the first code that applies: "SV", "PP", "FI", "34", "24", "PI". The code "SV" is recommended to be used prior to the mandated of use of National Provider ID.

CODE	DEFINITION
24	**Employer's Identification Number** **Use this code only when the 270/271 transaction sets are used by an employer inquiring about eligibility and benefits of their employees.**
34	**Social Security Number** **The social security number may not be used for any Federally administered programs such as Medicare.**
FI	**Federal Taxpayer's Identification Number**
PI	**Payor Identification** **Use this code only when the 270/271 transaction sets are used between two payers.**
PP	**Pharmacy Processor Number**
SV	**Service Provider Number** **Use this code for the identification number assigned by the information source to be used by the information receiver in health care transactions.**
XX	**Health Care Financing Administration National Provider Identifier** ***Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.*** **See code source 537.**

REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code	**X**	**AN**	**2/80**

INDUSTRY: ***Information Receiver Identification Number***

SYNTAX: P0809

Use this reference number as qualified by the preceding data element (NM108).

NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**

NOT USED	NM111	98	Entity Identifier Code	O	ID	2/3

IMPLEMENTATION

INFORMATION RECEIVER ADDITIONAL IDENTIFICATION

Loop: **2100B — INFORMATION RECEIVER NAME**

Usage: **SITUATIONAL**

Repeat: **9**

Notes: **1. Use this segment when needed to convey other or additional identification numbers for the information receiver. The type of reference number is determined by the qualifier in REF01.**

Example: **REF*EO*477563928~**

STANDARD

REF Reference Identification

Level: Detail

Position: 040

Loop: 2100

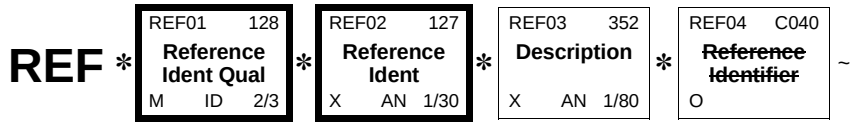
Requirement: Optional

Max Use: 9

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

Use this code to specify or qualify the type of reference number that is following in REF02, REF03, or both.

CODE	DEFINITION
0B	**State License Number** **The state assigning the license number must be identified in REF03.**

1C	**Medicare Provider Number** **This code is only to be used when the information source is not Medicare. If the information source is Medicare, the Medicare provider number is to be supplied in NM109 using Identification Code Qualifier of "SV" in NM108.**
1D	**Medicaid Provider Number** **This code is only to be used when the information source is not Medicaid. If the information source is Medicaid, the Medicaid provider number is to be supplied in NM109 using Identification Code Qualifier of "SV" in NM108.**
1J	**Facility ID Number**
4A	**Personal Identification Number (PIN)**
CT	**Contract Number** **This code is only to be used once the HCFA National Provider Identifier has been mandated for use, and must be sent if required in the contract between the provider identified in Loop 2000B and the Information Source identified in Loop 2000A.**
EL	**Electronic device pin number**
EO	**Submitter Identification Number**
HPI	**Health Care Financing Administration National Provider Identifier** **The Health Care Financing Administration National Provider Identifier may be used in this segment prior to being mandated for use.**
	CODE SOURCE **537:** Health Care Financing Administration National Provider Identifier
JD	**User Identification**
N5	**Provider Plan Network Identification Number**
N7	**Facility Network Identification Number**
Q4	**Prior Identifier Number**
SY	**Social Security Number** **The social security number may not be used for any Federally administered programs such as Medicare.**
TJ	**Federal Taxpayer's Identification Number**

REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Information Receiver Additional Identifier*** SYNTAX: R0203 **Use this reference number as qualified by the preceding data element (REF01).**	**X**	**AN**	**1/30**
SITUATIONAL	**REF03**	**352**	**Description** A free-form description to clarify the related data elements and their content *INDUSTRY:* ***License Number State Code*** SYNTAX: R0203 **Use this element for the two character state ID of the state assigning the identifier supplied in REF02. This element is required if the identifier supplied in REF02 is the State License Number. See Code source 22: States and Outlying Areas of the U.S.**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

INFORMATION RECEIVER ADDRESS

Loop: **2100B — INFORMATION RECEIVER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Use this segment if the information receiver is a provider who has multiple locations and it is needed to identify the location relative to the request.**

Example: **N3*201 PARK AVENUE*SUITE 300~**

STANDARD

N3 Address Information

Level: Detail

Position: 060

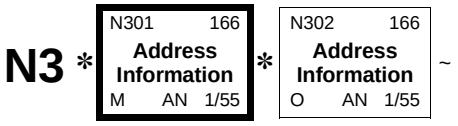
Loop: 2100

Requirement: Optional

Max Use: 1

Purpose: To specify the location of the named party

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N301**	**166**	**Address Information** Address information	**M**	**AN**	**1/55**
			INDUSTRY: ***Information Receiver Address Line***			
			Use this information for the first line of the address information.			
SITUATIONAL	**N302**	**166**	**Address Information** Address information	**O**	**AN**	**1/55**
			INDUSTRY: ***Information Receiver Additional Address Line***			
			Use this information for the second line of the address information.			
			Required if a second address line exists.			

IMPLEMENTATION

INFORMATION RECEIVER CITY/STATE/ZIP CODE

Loop: **2100B — INFORMATION RECEIVER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Use this segment if the information receiver is a provider who has multiple locations and it is needed to identify the location relative to the request.**

Example: **N4*NEW YORK*NY*10003~**

STANDARD

N4 Geographic Location

Level: Detail

Position: 070

Loop: 2100

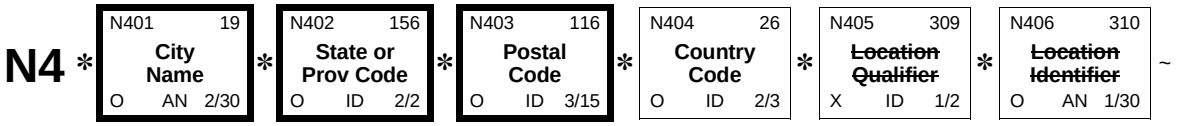
Requirement: Optional

Max Use: 1

Purpose: To specify the geographic place of the named party

Syntax: **1. C0605**
If N406 is present, then N405 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N401**	**19**	**City Name** Free-form text for city name *INDUSTRY:* ***Information Receiver City Name*** COMMENT: A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location. **Use this text for the city name of the information receiver's address.**	**O AN 2/30**

REQUIRED	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency	**O**	**ID**	**2/2**

INDUSTRY: ***Information Receiver State Code***

COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada.

CODE SOURCE 22: States and Outlying Areas of the U.S.

Use this code for the state code of the information receiver's address.

REQUIRED	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States)	**O**	**ID**	**3/15**

INDUSTRY: ***Information Receiver Postal Zone or ZIP Code***

CODE SOURCE 51: ZIP Code

Use this code for the ZIP or Postal Code of the information receiver's address.

SITUATIONAL	**N404**	**26**	**Country Code** Code identifying the country	**O**	**ID**	**2/3**

CODE SOURCE 5: Countries, Currencies and Funds

Use this code to specify the country of the information reciever's address, if other than the United States.

NOT USED	**N405**	**309**	**Location Qualifier**	**X**	**ID**	**1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O**	**AN**	**1/30**

IMPLEMENTATION

INFORMATION RECEIVER CONTACT INFORMATION

Loop: **2100B — INFORMATION RECEIVER NAME**

Usage: **SITUATIONAL**

Repeat: **3**

Notes:

1. **Use this segment when needed to identify a contact name and/or communications number for the entity identified. The segment allows for three contact numbers to be listed (e.g., telephone, extension, fax, EDI, or E-mail).**

   If a telephone extension is sent, it should always be in the occurrence of the communications number following the actual phone number. See the example for an illustration.

2. **If this segment is used, at a minimum either PER02 must be used or PER03 and PER04 must be used. It is recommended that at least PER02, PER03 and PER04 are sent if this segment is used.**

3. **When the communication number represents a telephone number in the United States and other countries using the North American Dialing Plan (for voice, data, fax, etc.), the communication number should always include the area code and phone number using the format AAABBBCCCC. Where AAA is the area code, BBB is the telephone number prefix, and CCCC is the telephone number (e.g. (534)224-2525 would be represented as 5342242525). The extension, when applicable, should be included in the communication number immediately after the telephone number.**

4. **By definition of the standard, if PER03 is used, PER04 is required.**

Example: **PER*IC*BILLING DEPT*TE*2128763654*EX*2104*FX*2128769304~**

STANDARD

PER Administrative Communications Contact

Level: Detail

Position: 080

Loop: 2100

Requirement: Optional

Max Use: 3

Purpose: To identify a person or office to whom administrative communications should be directed

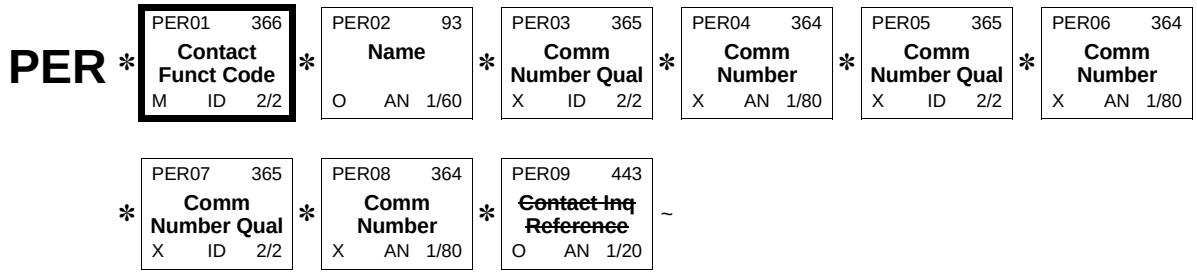
Syntax:

1. **P0304**
   If either PER03 or PER04 is present, then the other is required.

2. **P0506**
   If either PER05 or PER06 is present, then the other is required.

3. P0708
If either PER07 or PER08 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PER01**	**366**	**Contact Function Code** Code identifying the major duty or responsibility of the person or group named	**M ID 2/2**
			Use this code to specify the type of person or group to which the contact number applies.	
			CODE / DEFINITION	
			IC **Information Contact**	
SITUATIONAL	**PER02**	**93**	**Name** Free-form name	**O AN 1/60**
			*INDUSTRY: **Information Receiver Contact Name***	
			Use this name for the individual's name or group's name to use when contacting the individual or organization.	
			Use this data element when the name of the individual to contact is not already defined or is different than the name within the prior name segment (e.g. N1 or NM1).	
SITUATIONAL	**PER03**	**365**	**Communication Number Qualifier** Code identifying the type of communication number	**X ID 2/2**
			SYNTAX: P0304	
			Use this code to specify what type of communication number is following.	
			CODE / DEFINITION	
			ED **Electronic Data Interchange Access Number**	
			EM **Electronic Mail**	
			FX **Facsimile**	
			TE **Telephone**	

SITUATIONAL	**PER04**	**364**	**Communication Number** Complete communications number including country or area code when applicable	**X**	**AN**	**1/80**

INDUSTRY: ***Information Receiver Communication Number***

SYNTAX: P0304

Required when PER02 is not present or when a contact number is to be sent in addition to the contact name. Use this communication number as qualified by the preceding data element.

SITUATIONAL	**PER05**	**365**	**Communication Number Qualifier** Code identifying the type of communication number	**X**	**ID**	**2/2**

SYNTAX: P0506

Use this code to specify what type of communication number is following.

CODE	DEFINITION
ED	**Electronic Data Interchange Access Number**
EM	**Electronic Mail**
EX	**Telephone Extension**
FX	**Facsimile**
TE	**Telephone**

SITUATIONAL	**PER06**	**364**	**Communication Number** Complete communications number including country or area code when applicable	**X**	**AN**	**1/80**

INDUSTRY: ***Information Receiver Communication Number***

SYNTAX: P0506

Required when an additional contact number is to be sent. Use this communication number as qualified by the preceding data element.

The format for US domestic phone numbers is:
AAABBBCCCC
AAA = Area Code
BBBCCCC = Local Number

SITUATIONAL	**PER07**	**365**	**Communication Number Qualifier** Code identifying the type of communication number	**X**	**ID**	**2/2**

SYNTAX: P0708

Use this code to specify what type of communication number is following.

CODE	DEFINITION
ED	**Electronic Data Interchange Access Number**
EM	**Electronic Mail**
EX	**Telephone Extension**
FX	**Facsimile**
TE	**Telephone**

SITUATIONAL	**PER08**	**364**	**Communication Number** Complete communications number including country or area code when applicable *INDUSTRY:* ***Information Receiver Communication Number*** SYNTAX: P0708 **Required when an additional contact number is to be sent. Use this communication number as qualified by the preceding data element.** **The format for US domestic phone numbers is:** **AAABBBCCCC** **AAA = Area Code** **BBBCCCC = Local Number**	**X**	**AN**	**1/80**
NOT USED	**PER09**	**443**	**Contact Inquiry Reference**	**O**	**AN**	**1/20**

IMPLEMENTATION

INFORMATION RECEIVER PROVIDER INFORMATION

Loop: **2100B — INFORMATION RECEIVER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **This segment is used to convey additional information about a provider's role in the eligibility/benefit being inquired about and who is also the Information Receiver. For example, if the Information Receiver is also the Referring Provider, this PRV segment would be used to identify the provider's role.**

2. **PRV02 qualifies PRV03.**

Example: **PRV*PE*ZZ*203BA0504N~**

STANDARD

PRV Provider Information

Level: Detail

Position: 090

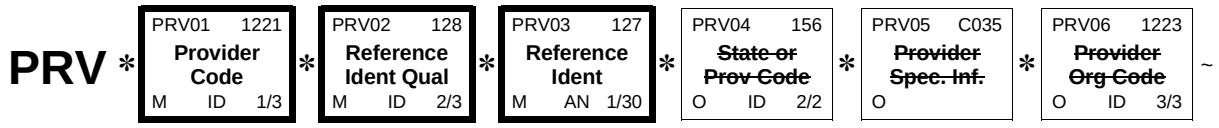
Loop: 2100

Requirement: Optional

Max Use: 1

Purpose: To specify the identifying characteristics of a provider

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PRV01**	**1221**	**Provider Code** Code indentifying the type of provider	**M ID 1/3**

CODE	DEFINITION
AD	**Admitting**
AT	**Attending**
BI	**Billing**
CO	**Consulting**
CV	**Covering**

			H	**Hospital**		
			HH	**Home Health Care**		
			LA	**Laboratory**		
			OT	**Other Physician**		
			P1	**Pharmacist**		
			P2	**Pharmacy**		
			PC	**Primary Care Physician**		
			PE	**Performing**		
			R	**Rural Health Clinic**		
			RF	**Referring**		
			SB	**Submitting**		
			SK	**Skilled Nursing Facility**		
			SU	**Supervising**		
REQUIRED	**PRV02**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M**	**ID**	**2/3**
			If the National Provider ID is mandated for use, code value "HPI" must be used, otherwise one of the other code values may be used.			
			CODE / **DEFINITION**			
			ZZ — **Mutually Defined** **ZZ is used to indicate the "Health Care Provider Taxonomy" code list (provider specialty code) which is available on the Washington Publishing Company web site: http://www.wpc-edi.com. This taxonomy is maintained by the Blue Cross Blue Shield Association and ASC X12N TG2 WG15.**			
REQUIRED	**PRV03**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**M**	**AN**	**1/30**
			INDUSTRY: ***Receiver Provider Specialty Code***			
			Use this number for the reference number as qualified by the preceding data element (PRV02).			
NOT USED	**PRV04**	**156**	**State or Province Code**	**O**	**ID**	**2/2**
NOT USED	**PRV05**	**C035**	**PROVIDER SPECIALTY INFORMATION**	**O**		
NOT USED	**PRV06**	**1223**	**Provider Organization Code**	**O**	**ID**	**3/3**

IMPLEMENTATION

SUBSCRIBER LEVEL

Loop: 2000C — SUBSCRIBER LEVEL **Repeat:** >1

Usage: REQUIRED

Repeat: 1

Notes:

1. If the transaction set is to be used in a real time mode (see section 1.3.2 for additional detail), it is required that the 270 transaction contain only one patient request. One patient is defined as either, one subscriber loop if the member is the patient, or one dependent loop if the dependent is the patient.

   If the transaction set is to be used in a batch mode (see section 1.3.2 for additional detail), it is required that the 270 transaction contain a maximum of ninety-nine patient requests. Each patient is defined as either, one subscriber loop if the member is the patient, or one subscriber loop and one dependent loop if the dependent is the patient.

   Although it is not recommended, if the number of patients is to be greater than one for real time mode or greater than ninety-nine for batch mode, the trading partners (the Information Source, the Information Receiver and the switch the transaction is routed through, if there is one involved) must all agree to exceed the number of patient requests and agree to a reasonable limit.

2. Use this segment to identify the hierarchical or entity level of information being conveyed. The HL structure allows for the efficient nesting of related occurrences of information. The developers' intent is to clearly identify the relationship of the patient to the subscriber and the subscriber to the provider.

   Additionally, multiple subscribers and/or dependents (i.e., the patient) can be grouped together under the same provider or the information for multiple providers or information receivers can be grouped together for the same payer or information source.

3. An example of the overall structure of the transaction set when used in batch mode is:

   Information Source (Loop 2000A)
   Information Receiver (Loop 2000B)
   Subscriber (Loop 2000C)
   Dependent (Loop 2000D)
   Eligibility or Benefit Inquiry
   Dependent (Loop 2000D)
   Eligibility or Benefit Inquiry
   Subscriber (Loop 2000C)
   Eligibility or Benefit Inquiry

Example: HL*3*2*22*1~

STANDARD

HL Hierarchical Level

Level: Detail

Position: 010

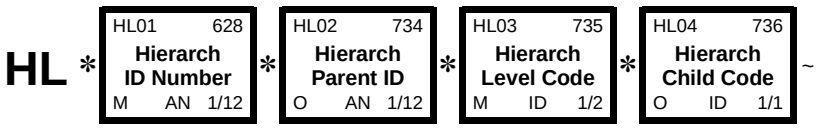
Loop: 2000 **Repeat:** >1

Requirement: Mandatory

Max Use: 1

Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure **COMMENT:** HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction. **Use this sequentially assigned positive number to identify each specific occurrence of an HL segment within a transaction set. It should begin with the number one and be incremented by one for each successive occurrence of the HL segment within that specific transaction set (ST through SE).** **An example of the use of the HL segment and this data element is:** **HL*1**20*1~** **NM1*PR*2*ABC INSURANCE COMPANY*****PI*842610001~** **HL*2*1*21*1~** **NM1*1P*1*JONES*MARCUS***MD*SV*0202034~** **HL*3*2*22*1~** **NM1*IL*1*SMITH*ROBERT*B***MI*11122333301~** **HL*4*3*23*0~** **NM1*03*1*SMITH*MARY*LOU~** **Eligibility/Benefit Data** **HL*5*2*22*0~** **NM1*IL*1*BROWN*JOHN*E***MI*22211333301~** **Eligibility/Benefit Data**	**M AN 1/12**

REQUIRED **HL02** **734** **Hierarchical Parent ID Number** **O AN 1/12**
Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to

COMMENT: HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.

Use this code to identify the specific hierarchical level to which this level is subordinate.

REQUIRED **HL03** **735** **Hierarchical Level Code** **M ID 1/2**
Code defining the characteristic of a level in a hierarchical structure

COMMENT: HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information.

All data that follows an HL segment is associated with the entity identified by the level code; this association continues until the next occurrence of an HL segment.

CODE	DEFINITION
22	**Subscriber**

REQUIRED **HL04** **736** **Hierarchical Child Code** **O ID 1/1**
Code indicating if there are hierarchical child data segments subordinate to the level being described

COMMENT: HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

Use this code to indicate whether there are additional hierarchical levels subordinate to the current hierarchical level.

If there is a Loop 2000D (Dependent) level subordinate to the current Loop 2000C, the value will be "1". If there is no Loop 2000D (Dependent) level subordinate to the current Loop 2000C, the value will be "0" (zero).

CODE	DEFINITION
0	**No Subordinate HL Segment in This Hierarchical Structure.**
1	**Additional Subordinate HL Data Segment in This Hierarchical Structure.**

IMPLEMENTATION

SUBSCRIBER TRACE NUMBER

Loop: **2000C — SUBSCRIBER LEVEL**

Usage: **SITUATIONAL**

Repeat: **2**

Notes:

1. **Trace numbers assigned at the subscriber level are intended to allow tracing of an eligibility/benefit transaction when the subscriber is the patient.**

2. **The information receiver may assign one TRN segment in this loop if the subscriber is the patient. A clearinghouse may assign one TRN segment in this loop if the subscriber is the patient. See Section 1.3.6 Information Linkage.**

Example: **TRN*1*98175-012547*9877281234*RADIOLOGY~**
TRN*1*109834652831*9XYZCLEARH*REALTIME~

STANDARD

TRN Trace

Level: Detail

Position: 020

Loop: 2000

Requirement: Optional

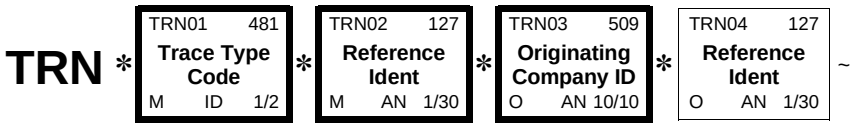
Max Use: 9

Purpose: To uniquely identify a transaction to an application

Set Notes:

1. If the Eligibility, Coverage or Benefit Inquiry Transaction Set (270) includes a TRN segment, then the Eligibility, Coverage or Benefit Information Transaction Set (271) must return the trace number identified in the TRN segment.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**TRN01**	**481**	**Trace Type Code** Code identifying which transaction is being referenced	**M ID 1/2**
			CODE: **1** — DEFINITION: **Current Transaction Trace Numbers**	

REQUIRED	**TRN02**	**127**	**Reference Identification**	**M**	**AN**	**1/30**

Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

INDUSTRY: ***Trace Number***

SEMANTIC: TRN02 provides unique identification for the transaction.

Use this number for the trace or reference number assigned by the information receiver.

REQUIRED	**TRN03**	**509**	**Originating Company Identifier**	**O**	**AN**	**10/10**

A unique identifier designating the company initiating the funds transfer instructions. The first character is one-digit ANSI identification code designation (ICD) followed by the nine-digit identification number which may be an IRS employer identification number (EIN), data universal numbering system (DUNS), or a user assigned number; the ICD for an EIN is 1, DUNS is 3, user assigned number is 9

INDUSTRY: ***Trace Assigning Entity Identifier***

SEMANTIC: TRN03 identifies an organization.

Use this number for the identification number of the company that assigned the trace or reference number specified in the previous data element (TRN02).

The first position must be either a “1" if an EIN is used, a ”3" if a DUNS is used or a “9" if a user assigned identifier is used.

SITUATIONAL	**TRN04**	**127**	**Reference Identification**	**O**	**AN**	**1/30**

Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

INDUSTRY: ***Trace Assigning Entity Additional Identifier***

SEMANTIC: TRN04 identifies a further subdivision within the organization.

Use this information if necessary to further identify a specific component of the company identified in the previous data element (TRN03). This information allows the originating company to further identify a specific division or group within that organization that was responsible for assigning the trace or reference number.

IMPLEMENTATION

SUBSCRIBER NAME

Loop: **2100C — SUBSCRIBER NAME** **Repeat:** **1**

Usage: **REQUIRED**

Repeat: **1**

Notes:

1. **Use this segment to identify an entity by name and/or identification number. Use this NM1 loop to identify the insured or subscriber.**
2. **Please refer to Section 1.3.8 Search Options for specific information about how to identify an individual to an Information Source.**

Example: **NM1*IL*1*SMITH*JOHN*L***34*444115555~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 030

Loop: 2100 **Repeat:** >1

Requirement: Mandatory

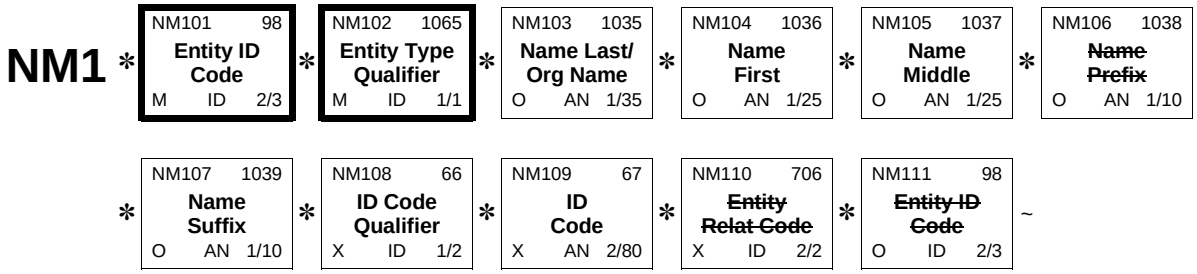
Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M ID 2/3**

CODE	DEFINITION
IL	**Insured or Subscriber**

REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity	**M**	**ID**	**1/1**

SEMANTIC: NM102 qualifies NM103.

Use this code to indicate whether the entity is an individual person or an organization.

CODE	DEFINITION
1	**Person**

SITUATIONAL	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name	**O**	**AN**	**1/35**

INDUSTRY: ***Subscriber Last Name***

Use this name for the subscriber's last name.

Use this name if the subscriber is the patient and if utilizing the HIPAA search option. See Section 1.3.8 for more information.

SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name	**O**	**AN**	**1/25**

INDUSTRY: ***Subscriber First Name***

Use this name for the subscriber's first name.

Use this name if the subscriber is the patient and if utilizing the HIPAA search option. See Section 1.3.8 for more information.

SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial	**O**	**AN**	**1/25**

INDUSTRY: ***Subscriber Middle Name***

Use this name for the subscriber's middle name or initial. Use if information is known and will assist in identification of the person named, particularly when not utilizing the HIPAA search option.

NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**AN**	**1/10**
SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name	**O**	**AN**	**1/10**

INDUSTRY: ***Subscriber Name Suffix***

Use this for the suffix to an individual's name; e.g., Sr., Jr. or III. Use if information is known and will assist in identification of the person named, particularly when not utilizing the HIPAA search option.

SITUATIONAL	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67)	**X**	**ID**	**1/2**

SYNTAX: P0809

Use this element to qualify the identification number submitted in NM109. This is the primary number that the information source associates with the subscriber.

Use this element if utilizing the HIPAA search option. See Section 1.3.8 for more information.

CODE	DEFINITION
MI	**Member Identification Number** **This code may only be used prior to the mandated use of code "ZZ". This is the unique number the payer or information source uses to identify the insured (e.g., Health Insurance Claim Number, Medicaid Recipient ID Number, HMO Member ID, etc.).**
ZZ	**Mutually Defined** **The value 'ZZ', when used in this data element shall be defined as "HIPAA Individual Identifier" once this identifier has been adopted. Under the Health Insurance Portability and Accountability Act of 1996, the Secretary of the Department of Health and Human Services must adopt a standard individual identifier for use in this transaction.**

SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code	**X**	**AN**	**2/80**

INDUSTRY: ***Subscriber Primary Identifier***

SYNTAX: P0809

Use this reference number as qualified by the preceding data element (NM108).

Use this element if utilizing the HIPAA search option. See Section 1.3.8 for more information.

NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

SUBSCRIBER ADDITIONAL IDENTIFICATION

Loop: **2100C — SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **9**

Notes:

1. **Use this segment when needed to convey identification numbers other than or in addition to the Member Identification Number. The type of reference number is determined by the qualifier in REF01.**

2. **Health Insurance Claim (HIC) Number or Medicaid Recipient Identification Numbers are to be provided in the NM1 segment as a Member Identification Number when it is the primary number an information source knows a member by (such as for Medicare or Medicaid). Do not use this segment for the Health Insurance Claim (HIC) Number or Medicaid Recipient Identification Number unless they are different from the Member Identification Number provided in the NM1 segment.**

3. **Please refer to Section 1.3.8 Search Options for specific information about how to identify an individual to an Information Source.**

Example: **REF*1L*660415~**

STANDARD

REF Reference Identification

Level: Detail

Position: 040

Loop: 2100

Requirement: Optional

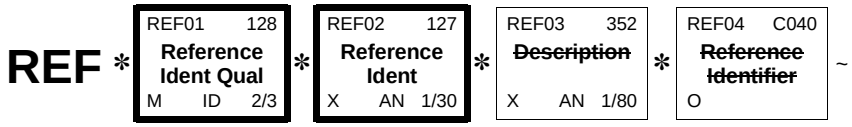
Max Use: 9

Purpose: To specify identifying information

Syntax:

1. **R0203**
   At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	**Reference Identification Qualifier** Code qualifying the Reference Identification	M ID 2/3

Use this code to specify or qualify the type of reference number that is following in REF02, REF03, or both.

CODE	DEFINITION
18	Plan Number
1L	Group or Policy Number Use this code only if it cannot be determined if the number is a Group Number or a Policy number. Use codes “IG” or “6P” when they can be determined.
1W	Member Identification Number Use only after the Unique Patient Identifier is available and has been provided in the NM109, but use of the UPI has not been mandated.
49	Family Unit Number Suffix to the Subscriber’s Member Identification Number. This suffix allows the information source to use one identification number as the base number for each family member. The suffix identifies the individual family member. Only the suffix is to be entered here. The Member Identification Number is to be entered in Loop 2100C NM109 or REF02. If the complete Member Identification Number with the suffix is entered in Loop 2100C NM109 or REF02, the suffix should not be entered here.
6P	Group Number
A6	Employee Identification Number
CT	Contract Number This code is to be used only to identify the provider’s contract number of the provider identified in the PRV segment of Loop 2100C. This code is only to be used once the HCFA National Provider Identifier has been mandated for use, and must be sent if required in the contract between the Information Receiver identified in Loop 2100B and the Information Source identified in Loop 2100A.
EA	Medical Record Identification Number
EJ	Patient Account Number
F6	Health Insurance Claim (HIC) Number See segment note 2.

			GH	**Identification Card Serial Number** **Use this code when the Identification Card has a number in addition to the Member Identification Number or Identity Card Number. The Identification Card Serial Number uniquely identifies the card when multiple cards have been or will be issued to a member (e.g., on a monthly basis, replacement cards). This is particularly prevalent in the Medicaid environment.**			
			HJ	**Identity Card Number** **Use this code when the Identity Card Number is different than the Member Identification Number. This is particularly prevalent in the Medicaid environment.**			
			IG	**Insurance Policy Number**			
			N6	**Plan Network Identification Number**			
			NQ	**Medicaid Recipient Identification Number** **See segment note 2.**			
			SY	**Social Security Number** **The social security number may not be used for any Federally administered programs such as Medicare.**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Subscriber Supplemental Identifier*** SYNTAX: R0203 **Use this reference number as qualified by the preceding data element (REF01).**	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

SUBSCRIBER ADDRESS

Loop: **2100C — SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Use this segment when needed to convey the address information for the subscriber. Use if information is known and will assist in identification of the person named, particularly when not utilizing the HIPAA search option.**

Example: **N3*15197 BROADWAY AVENUE*APT 215~**

STANDARD

N3 Address Information

Level: Detail

Position: 060

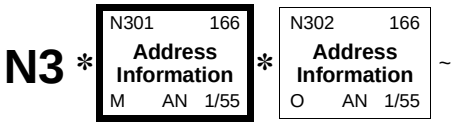
Loop: 2100

Requirement: Optional

Max Use: 1

Purpose: To specify the location of the named party

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N301**	**166**	**Address Information** Address information	**M**	**AN**	**1/55**
			INDUSTRY: ***Subscriber Address Line***			
			Use this information for the first line of the address information.			
SITUATIONAL	**N302**	**166**	**Address Information** Address information	**O**	**AN**	**1/55**
			INDUSTRY: ***Subscriber Address Line***			
			Use this information for the second line of the address information.			
			Required if a second address line exists.			

IMPLEMENTATION

SUBSCRIBER CITY/STATE/ZIP CODE

Loop: **2100C — SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Use this segment when needed to convey the city, state, and ZIP code for the subscriber. Use if information is known and will assist in identification of the person named, particularly when not utilizing the HIPAA search option.**

Example: **N4*NEW YORK*NY*10003~**

STANDARD

N4 Geographic Location

Level: Detail

Position: 070

Loop: 2100

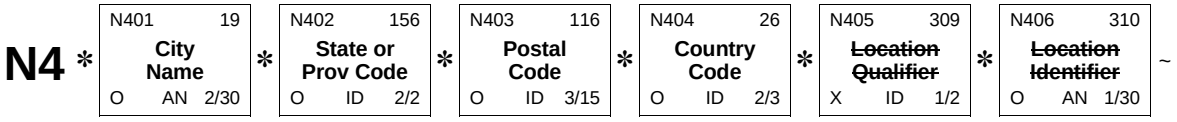
Requirement: Optional

Max Use: 1

Purpose: To specify the geographic place of the named party

Syntax: **1. C0605**
If N406 is present, then N405 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**N401**	**19**	**City Name** Free-form text for city name *INDUSTRY:* ***Subscriber City Name*** **COMMENT:** A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location. **Use this text for the city name of the subscriber's address.**	**O AN 2/30**

SITUATIONAL	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency	**O**	**ID**	**2/2**

INDUSTRY: ***Subscriber State Code***

COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada.

CODE SOURCE **22:** States and Outlying Areas of the U.S.

Use this code for the state code of the subscriber's address.

SITUATIONAL	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States)	**O**	**ID**	**3/15**

INDUSTRY: ***Subscriber Postal Zone or ZIP Code***

CODE SOURCE **51:** ZIP Code

Use this code for the ZIP or Postal Code of the subscriber's address.

SITUATIONAL	**N404**	**26**	**Country Code** Code identifying the country	**O**	**ID**	**2/3**

CODE SOURCE **5:** Countries, Currencies and Funds

Use this code to specify the country of the subscriber's address, if other than the United States.

NOT USED	**N405**	**309**	**Location Qualifier**	**X**	**ID**	**1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O**	**AN**	**1/30**

IMPLEMENTATION

PROVIDER INFORMATION

Loop: **2100C — SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Use this segment when needed to either to identify a specific provider or associate a specialty type related to the service identified in the 2110C loop.**
2. **If identifying a specific provider, use this segment to convey specific information about a provider's role in the eligibility/benefit being inquired about when the provider is not the information receiver. For example, if the information receiver is a hospital and a referring provider must be identified, this is the segment where the referring provider would be identified.**
3. **If identifying a specific provider, this segment contains reference identification numbers, all of which may be used up until the time the National Provider Identifier (NPI) is mandated for use. After the NPI is mandated, only the code for National Provider Identifier may be used.**
4. **If identifying a type of specialty associated with the services identified in loop 2110C, use code ZZ in PRV02 and the appropriate code in PRV03.**
5. **PRV02 qualifies PRV03.**

Example: **PRV*PE*EI*9991234567~**
PRV*PE*ZZ*203BA0504N~

STANDARD

PRV Provider Information

Level: Detail

Position: 090

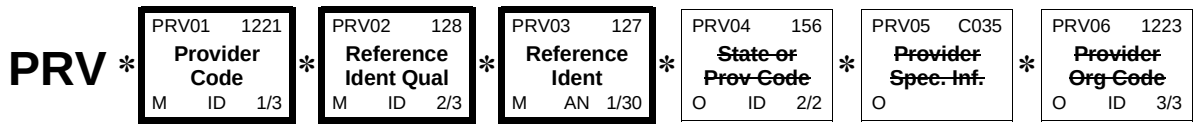
Loop: 2100

Requirement: Optional

Max Use: 1

Purpose: To specify the identifying characteristics of a provider

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	PRV01	1221	**Provider Code** Code indentifying the type of provider	M	ID	1/3

CODE	DEFINITION
AD	Admitting
AT	Attending
BI	Billing
CO	Consulting
CV	Covering
H	Hospital
HH	Home Health Care
LA	Laboratory
OT	Other Physician
P1	Pharmacist
P2	Pharmacy
PC	Primary Care Physician
PE	Performing
R	Rural Health Clinic
RF	Referring
SB	Submitting
SK	Skilled Nursing Facility
SU	Supervising

REQUIRED	**PRV02**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M**	**ID**	**2/3**

If this segment is used to identify a specific provider and the National Provider ID is mandated for use, code value "HPI" must be used, otherwise one of the other code values may be used.

If this segment is used to identify a type of specialty associated with the services identified in loop 2110C, use code ZZ. ZZ is used to indicate the "Health Care Provider Taxonomy" code list (provider specialty code) which is available on the Washington Publishing Company web site: http://www.wpc-edi.com. This taxonomy is maintained by the Blue Cross Blue Shield Association and ASC X12N TG2 WG15.

CODE	DEFINITION
9K	**Servicer** **Use this code for the identification number assigned by the information source to be used by the information receiver in health care transactions.**
D3	**National Association of Boards of Pharmacy Number**
	CODE SOURCE **307:** National Association of Boards of Pharmacy Number
EI	**Employer's Identification Number**
HPI	**Health Care Financing Administration National Provider Identifier** **Required value when identifying a specific provider when the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.**
	CODE SOURCE **537:** Health Care Financing Administration National Provider Identifier
SY	**Social Security Number** **The social security number may not be used for any Federally administered programs such as Medicare.**
TJ	**Federal Taxpayer's Identification Number**
ZZ	**Mutually Defined** **Health Care Provider Taxonomy Code list.**

REQUIRED	**PRV03**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**M**	**AN**	**1/30**

INDUSTRY: ***Provider Identifier***

Use this number for the reference number as qualified by the preceding data element (PRV02).

NOT USED	**PRV04**	**156**	**State or Province Code**	**O**	**ID**	**2/2**
NOT USED	**PRV05**	**C035**	**PROVIDER SPECIALTY INFORMATION**	**O**		
NOT USED	**PRV06**	**1223**	**Provider Organization Code**	**O**	**ID**	**3/3**

IMPLEMENTATION

SUBSCRIBER DEMOGRAPHIC INFORMATION

Loop: **2100C — SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Use this segment when needed to convey birth date or gender demographic information for the subscriber.**
2. **Please refer to Section 1.3.8 Search Options for specific information about how to identify an individual to an Information Source.**

Example: **DMG*D8*19430917*M~**

STANDARD

DMG Demographic Information

Level: Detail

Position: 100

Loop: 2100

Requirement: Optional

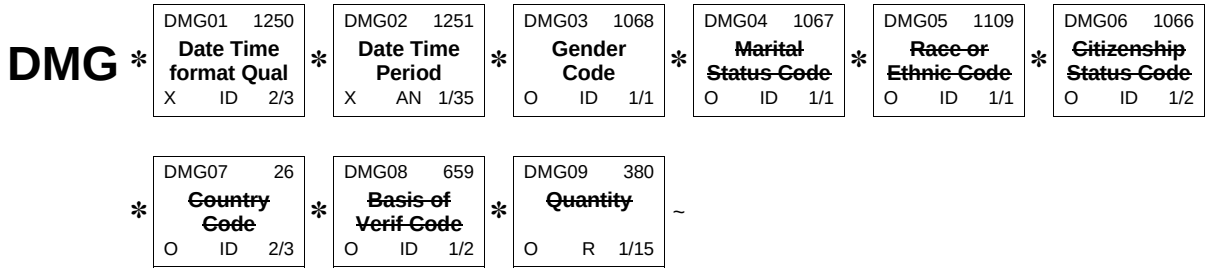
Max Use: 1

Purpose: To supply demographic information

Syntax:

1. **P0102**
   If either DMG01 or DMG02 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	DMG01	1250	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format SYNTAX: P0102 **Use this code to indicate the format of the date of birth that follows in DMG02.** **Use this element if the subscriber is the patient and if utilizing the HIPAA search option. See Section 1.3.8 for more information.** CODE — DEFINITION D8 — Date Expressed in Format CCYYMMDD	X ID 2/3
SITUATIONAL	DMG02	1251	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: ***Subscriber Birth Date*** SYNTAX: P0102 SEMANTIC: DMG02 is the date of birth. **Use this date for the date of birth of the individual.** **Use this element if the subscriber is the patient and if utilizing the HIPAA search option. See Section 1.3.8 for more information.**	X AN 1/35
SITUATIONAL	DMG03	1068	**Gender Code** Code indicating the sex of the individual INDUSTRY: ***Subscriber Gender Code*** **Use this code to indicate the subscriber's gender.** **Use if information is known and will assist in identification of the person named, particularly when not utilizing the HIPAA search option.** CODE — DEFINITION F — Female M — Male	O ID 1/1
NOT USED	DMG04	1067	**Marital Status Code**	O ID 1/1
NOT USED	DMG05	1109	**Race or Ethnicity Code**	O ID 1/1
NOT USED	DMG06	1066	**Citizenship Status Code**	O ID 1/2
NOT USED	DMG07	26	**Country Code**	O ID 2/3
NOT USED	DMG08	659	**Basis of Verification Code**	O ID 1/2
NOT USED	DMG09	380	**Quantity**	O R 1/15

IMPLEMENTATION

SUBSCRIBER RELATIONSHIP

Loop: **2100C — SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Use this segment only in the absence of all of the data for the mandated search option identified in Section 1.3.8. and only if it is necessary to identify the birth sequence of the subscriber in the case of multiple births with the same birth date.**

Example: **INS*Y*18**********3~**

STANDARD

INS Insured Benefit

Level: Detail

Position: 110

Loop: 2100

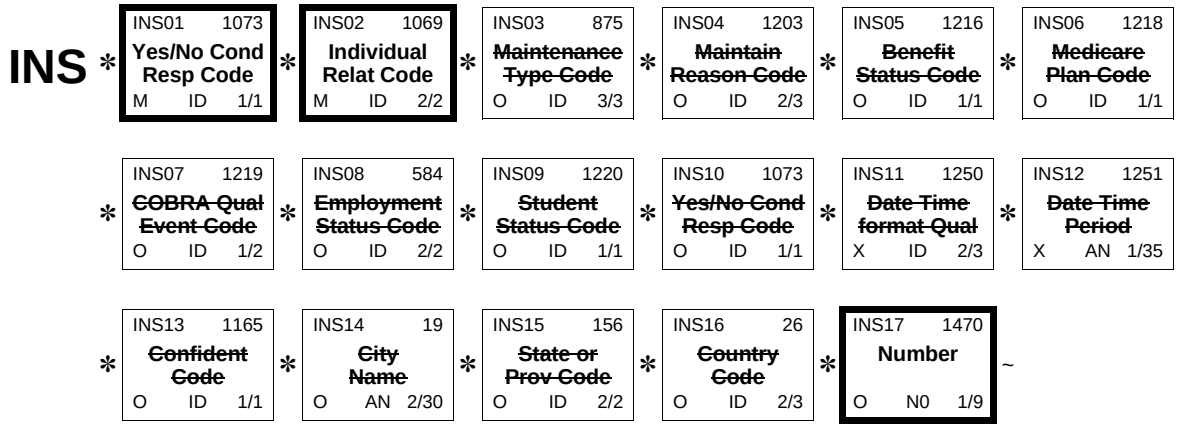
Requirement: Optional

Max Use: 1

Purpose: To provide benefit information on insured entities

Syntax: **1. P1112**
If either INS11 or INS12 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	INS01	1073	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response *INDUSTRY:* ***Insured Indicator*** SEMANTIC: INS01 indicates status of the insured. A "Y" value indicates the insured is a subscriber: an "N" value indicates the insured is a dependent. CODE — DEFINITION **Y — Yes**	M	ID	1/1
REQUIRED	INS02	1069	**Individual Relationship Code** Code indicating the relationship between two individuals or entities CODE — DEFINITION **18 — Self**	M	ID	2/2
NOT USED	INS03	875	**Maintenance Type Code**	O	ID	3/3
NOT USED	INS04	1203	**Maintenance Reason Code**	O	ID	2/3
NOT USED	INS05	1216	**Benefit Status Code**	O	ID	1/1
NOT USED	INS06	1218	**Medicare Plan Code**	O	ID	1/1
NOT USED	INS07	1219	**Consolidated Omnibus Budget Reconciliation Act (COBRA) Qualifying**	O	ID	1/2
NOT USED	INS08	584	**Employment Status Code**	O	ID	2/2
NOT USED	INS09	1220	**Student Status Code**	O	ID	1/1
NOT USED	INS10	1073	**Yes/No Condition or Response Code**	O	ID	1/1
NOT USED	INS11	1250	**Date Time Period Format Qualifier**	X	ID	2/3
NOT USED	INS12	1251	**Date Time Period**	X	AN	1/35
NOT USED	INS13	1165	**Confidentiality Code**	O	ID	1/1
NOT USED	INS14	19	**City Name**	O	AN	2/30
NOT USED	INS15	156	**State or Province Code**	O	ID	2/2
NOT USED	INS16	26	**Country Code**	O	ID	2/3
REQUIRED	INS17	1470	**Number** A generic number *INDUSTRY:* ***Birth Sequence Number*** SEMANTIC: INS17 is the number assigned to each family member born with the same birth date. This number identifies birth sequence for multiple births allowing proper tracking and response of benefits for each dependent (i.e., twins, triplets, etc.). **Use to indicate the birth order in the event of multiple birth's in association with the birth date supplied in DMG02.**	O	N0	1/9

IMPLEMENTATION

SUBSCRIBER DATE

Loop: **2100C — SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **2**

Notes:

1. **Use this segment to convey the eligibility, service or admission date(s) for the subscriber or for the issue date of the subscriber's identification card for the information source (e.g., Medicaid ID card). Absence of an Eligibility, Admission or Service date implies the request is for the date the transaction is processed.**

2. **When using codes "307" (Eligibility), "435" (Admission) or "472" (Service) at this level, it is implied that these dates apply to all of the Eligibility or Benefit Inquiry (EQ) loops that follow. If there is a need to supply a different Eligibility, Admission or Service date for a specific EQ loop, it must be provided in the DTP segment within the EQ loop and it will only apply to that EQ loop.**

Example: **DTP*102*D8*19950818~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 120

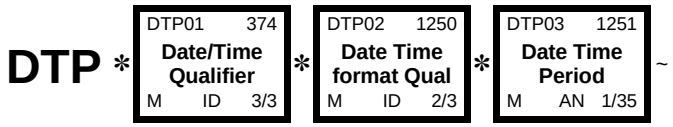
Loop: 2100

Requirement: Optional

Max Use: 9

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time *INDUSTRY:* ***Date Time Qualifier*** **Only one of the following codes may be used per request: 307 - Eligibility, 435 - Admission or 472 - Service.** **102** **Issue** **Used if utilizing a search option other than the HIPAA search option identified in section 1.3.8 and is present on the identification card and is available.** **307** **Eligibility** **435** **Admission** **472** **Service**	**M ID 3/3**
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **SEMANTIC:** DTP02 is the date or time or period format that will appear in DTP03. **D8** **Date Expressed in Format CCYYMMDD** **RD8** **Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD**	**M ID 2/3**
REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times **Use this date for the date(s) as qualified by the preceding data elements.**	**M AN 1/35**

IMPLEMENTATION

SUBSCRIBER ELIGIBILITY OR BENEFIT INQUIRY INFORMATION

Loop: **2110C — SUBSCRIBER ELIGIBILITY OR BENEFIT INQUIRY INFORMATION Repeat: 99**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Use this segment to begin the eligibility/benefit inquiry looping structure.**

2. **Use the EQ loop/segment when the subscriber is the patient whose eligibility or benefits are being verified. When the subscriber is not the patient, this loop must not be used.**

3. **If the EQ segment is used, either EQ01 - Service Type Code or EQ02 - Composite Medical Procedure Identifier must be used. Only EQ01 or EQ02 is to be sent, not both.**
   An information source must support a generic request for Eligibility. This is accomplished by submitting a Service Type Code of "30" (Health Benefit Plan Coverage) in EQ01. An information source may support the use of Service Type Codes other than "30" (Health Benefit Plan Coverage) in EQ01 at their discretion.
   An information source may support the use of EQ02 - Composite Medical Procedure Identifier at their discretion. The EQ02 allows for a very specific inquiry, such as one based on a procedure code. Additional information such as diagnosis codes and place of service can be supplied in the III segment of loop 2110C.

4. **If an inquiry is submitted with a Service Type Code from the list other than "30" and the information source does not support this level of functionality, a generic response will be returned. The generic response will be the same response as if a Service Type Code of "30" (Health Benefit Plan Coverage) was received by the information source. Refer to Section 1.3.6 for additional information.**

Example: **EQ*30**FAM*GP~**

STANDARD

EQ Eligibility or Benefit Inquiry

Level: Detail

Position: 130

Loop: 2110 **Repeat:** 99

Requirement: Optional

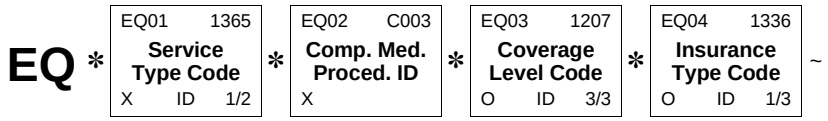
Max Use: 1

Purpose: To specify inquired eligibility or benefit information

Syntax:

1. **R0102**
   At least one of EQ01 or EQ02 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	EQ01	1365	**Service Type Code** Code identifying the classification of service SYNTAX: R0102	X ID 1/2

An information source must support a generic request for Eligibility. This is accomplished by submitting a Service Type Code of "30" (Health Benefit Plan Coverage) in EQ01.

An information source may support the use of Service Type Codes from the list other than "30" (Health Benefit Plan Coverage) in EQ01 at their discretion. If an information source supports codes in addition to "30", the information source may provide a list of the supported codes from the list below to the information receiver. If no list is provided, an information receiver may transmit the most appropriate code.

If an inquiry is submitted with a Service Type Code from the list other than "30" and the information source does not support this level of functionality, a generic response will be returned. The generic response will be the same response as if a Service Type Code of "30" (Health Benefit Plan Coverage) was received by the information source. Refer to Section 1.3.6 for additional information.

Not used if EQ02 is used.

CODE	DEFINITION
1	Medical Care
2	Surgical
3	Consultation
4	Diagnostic X-Ray
5	Diagnostic Lab
6	Radiation Therapy
7	Anesthesia
8	Surgical Assistance
9	Other Medical
10	Blood Charges
11	Used Durable Medical Equipment

12	Durable Medical Equipment Purchase
13	Ambulatory Service Center Facility
14	Renal Supplies in the Home
15	Alternate Method Dialysis
16	Chronic Renal Disease (CRD) Equipment
17	Pre-Admission Testing
18	Durable Medical Equipment Rental
19	Pneumonia Vaccine
20	Second Surgical Opinion
21	Third Surgical Opinion
22	Social Work
23	Diagnostic Dental
24	Periodontics
25	Restorative
26	Endodontics
27	Maxillofacial Prosthetics
28	Adjunctive Dental Services
30	Health Benefit Plan Coverage If only a single category of inquiry can be supported, use this code.
32	Plan Waiting Period
33	Chiropractic
34	Chiropractic Office Visits
35	Dental Care
36	Dental Crowns
37	Dental Accident
38	Orthodontics
39	Prosthodontics
40	Oral Surgery
41	Routine (Preventive) Dental
42	Home Health Care
43	Home Health Prescriptions
44	Home Health Visits

45	Hospice
46	Respite Care
47	Hospital
48	Hospital - Inpatient
49	Hospital - Room and Board
50	Hospital - Outpatient
51	Hospital - Emergency Accident
52	Hospital - Emergency Medical
53	Hospital - Ambulatory Surgical
54	Long Term Care
55	Major Medical
56	Medically Related Transportation
57	Air Transportation
58	Cabulance
59	Licensed Ambulance
60	General Benefits
61	In-vitro Fertilization
62	MRI/CAT Scan
63	Donor Procedures
64	Acupuncture
65	Newborn Care
66	Pathology
67	Smoking Cessation
68	Well Baby Care
69	Maternity
70	Transplants
71	Audiology Exam
72	Inhalation Therapy
73	Diagnostic Medical
74	Private Duty Nursing
75	Prosthetic Device

76	Dialysis
77	Otological Exam
78	Chemotherapy
79	Allergy Testing
80	Immunizations
81	Routine Physical
82	Family Planning
83	Infertility
84	Abortion
85	AIDS
86	Emergency Services
87	Cancer
88	Pharmacy
89	Free Standing Prescription Drug
90	Mail Order Prescription Drug
91	Brand Name Prescription Drug
92	Generic Prescription Drug
93	Podiatry
94	Podiatry - Office Visits
95	Podiatry - Nursing Home Visits
96	Professional (Physician)
97	Anesthesiologist
98	Professional (Physician) Visit - Office
99	Professional (Physician) Visit - Inpatient
A0	Professional (Physician) Visit - Outpatient
A1	Professional (Physician) Visit - Nursing Home
A2	Professional (Physician) Visit - Skilled Nursing Facility
A3	Professional (Physician) Visit - Home
A4	Psychiatric
A5	Psychiatric - Room and Board
A6	Psychotherapy

A7	Psychiatric - Inpatient
A8	Psychiatric - Outpatient
A9	Rehabilitation
AA	Rehabilitation - Room and Board
AB	Rehabilitation - Inpatient
AC	Rehabilitation - Outpatient
AD	Occupational Therapy
AE	Physical Medicine
AF	Speech Therapy
AG	Skilled Nursing Care
AH	Skilled Nursing Care - Room and Board
AI	Substance Abuse
AJ	Alcoholism
AK	Drug Addiction
AL	Vision (Optometry)
AM	Frames
AN	Routine Exam
AO	Lenses
AQ	Nonmedically Necessary Physical
AR	Experimental Drug Therapy
BA	Independent Medical Evaluation
BB	Partial Hospitalization (Psychiatric)
BC	Day Care (Psychiatric)
BD	Cognitive Therapy
BE	Massage Therapy
BF	Pulmonary Rehabilitation
BG	Cardiac Rehabilitation
BH	Pediatric
BI	Nursery
BJ	Skin
BK	Orthopedic
BL	Cardiac

BM	**Lymphatic**
BN	**Gastrointestinal**
BP	**Endocrine**
BQ	**Neurology**
BR	**Eye**
BS	**Invasive Procedures**

SITUATIONAL **EQ02** **C003** **COMPOSITE MEDICAL PROCEDURE IDENTIFIER** **X**

To identify a medical procedure by its standardized codes and applicable modifiers

An information source may support the use of EQ02 - Composite Medical Procedure Identifier at their discretion. The EQ02 allows for a very specific inquiry, such as one based on a procedure code. Additional information such as diagnosis codes and place of service can be supplied in the III segment of loop 2110C.

If an inquiry is submitted with EQ02 and the information source does not support this level of functionality, a generic response will be returned. The generic response will be the same response as if a Service Type Code of "30" (Health Benefit Plan Coverage) was received by the information source. Refer to Section 1.3.6 for additional information.

Not used if EQ01 is used.

REQUIRED **EQ02 - 1** **235** **Product/Service ID Qualifier** **M** **ID** **2/2**

Code identifying the type/source of the descriptive number used in Product/Service ID (234)

INDUSTRY: ***Product or Service ID Qualifier***

Use this code to qualify the type of specific Product/Service ID that will be used in EQ02-2.

CODE	DEFINITION
AD	**American Dental Association Codes**
	CODE SOURCE 135: American Dental Association Codes
CJ	**Current Procedural Terminology (CPT) Codes**
	CODE SOURCE 133: Current Procedural Terminology (CPT) Codes
HC	**Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes**
	CODE SOURCE 130: Health Care Financing Administration Common Procedural Coding System
ID	**International Classification of Diseases Clinical Modification (ICD-9-CM) - Procedure**
	CODE SOURCE 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure
IV	**Home Infusion EDI Coalition (HIEC) Product/Service Code**
	CODE SOURCE 513: Home Infusion EDI Coalition (HIEC) Product/Service Code List

		ND	**National Drug Code (NDC)** CODE SOURCE **134:** National Drug Code			
		ZZ	**Mutually Defined** **NOT ADVISED** **Use this code only for local codes or interim uses until an appropriate new code is approved.**			
REQUIRED	**EQ02 - 2**	**234**	**Product/Service ID** Identifying number for a product or service *INDUSTRY:* ***Procedure Code*** **Use this number for the product/service ID as identified by the preceding data element (EQ02-1).**	**M**	**AN**	**1/48**
SITUATIONAL	**EQ02 - 3**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners **Used when an information source supports or may be thought to support this high level of functionality if modifiers are required to further specify the service. If not supported, information source will process without this data element.**	**O**	**AN**	**2/2**
SITUATIONAL	**EQ02 - 4**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners **Used when an information source supports or may be thought to support this high level of functionality if modifiers are required to further specify the service. If not supported, information source will process without this data element.**	**O**	**AN**	**2/2**
SITUATIONAL	**EQ02 - 5**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners **Used when an information source supports or may be thought to support this high level of functionality if modifiers are required to further specify the service. If not supported, information source will process without this data element.**	**O**	**AN**	**2/2**
SITUATIONAL	**EQ02 - 6**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners **Used when an information source supports or may be thought to support this high level of functionality if modifiers are required to further specify the service. If not supported, information source will process without this data element.**	**O**	**AN**	**2/2**
NOT USED	**EQ02 - 7**	**352**	**Description**	**O**	**AN**	**1/80**

SITUATIONAL **EQ03** **1207** **Coverage Level Code** **O** **ID** **3/3**
Code indicating the level of coverage being provided for this insured

INDUSTRY: ***Benefit Coverage Level Code***

Use EQ03 when an information source supports or may be thought to support the function of identifying benefits by the Benefit Coverage Level Code. Use this code to identify the types and number of entities that the request is to apply to. If not supported, the information source will process without this data element.

CODE	DEFINITION
CHD	Children Only
DEP	Dependents Only
ECH	Employee and Children
EMP	Employee Only
ESP	Employee and Spouse
FAM	Family
IND	Individual
SPC	Spouse and Children
SPO	Spouse Only

SITUATIONAL **EQ04** **1336** **Insurance Type Code** **O** **ID** **1/3**
Code identifying the type of insurance policy within a specific insurance program

Use this code to identify the specific type of insurance the inquiry applies to if the information source has multiple insurance lines that apply to the person being inquired about. Do not use if the insurance type can be determined either by the person's identifiers or the information source's identifiers.

CODE	DEFINITION
AP	Auto Insurance Policy
C1	Commercial
CO	Consolidated Omnibus Budget Reconciliation Act (COBRA)
GP	Group Policy
HM	Health Maintenance Organization (HMO)
HN	Health Maintenance Organization (HMO) - Medicare Risk
IP	Individual Policy
MA	Medicare Part A
MB	Medicare Part B
MC	Medicaid

PR	**Preferred Provider Organization (PPO)**
PS	**Point of Service (POS)**
SP	**Supplemental Policy**
WC	**Workers Compensation**

IMPLEMENTATION

SUBSCRIBER SPEND DOWN AMOUNT

Loop: **2110C — SUBSCRIBER ELIGIBILITY OR BENEFIT INQUIRY INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Use this segment only if it is necessary to report a Spend Down amount. Under certain Medicaid programs, individuals must indicate the dollar amount that they wish to apply towards their deductible. These programs require individuals to pay a certain amount towards their health care cost before Medicaid coverage starts.**

2. **If the EQ segment is used, either EQ01 - Service Type Code or EQ02 - Composite Medical Procedure Identifier must be used. EQ02 - Composite Medical Procedure Identifier is used only if an information source can support this high-level functionality. The EQ02 allows for a very specific inquiry, such as on based on a procedure code. Additional information such as diagnosis codes and place of service can be supplied in the III segment of loop 2110C. If this level of functionality is not supported, use EQ01.**

Example: **AMT*R*37.5~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 135

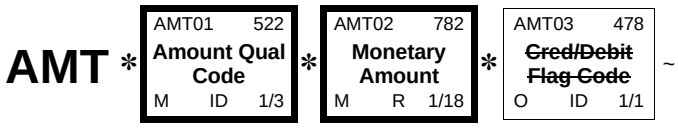
Loop: 2110

Requirement: Optional

Max Use: 2

Purpose: To indicate the total monetary amount

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AMT01**	**522**	**Amount Qualifier Code** Code to qualify amount	**M ID 1/3**

CODE	DEFINITION
R	**Spend Down**

REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount	**M**	**R**	**1/18**
			INDUSTRY: ***Spend Down Amount***			
			Use this monetary amount to specify the dollar amount associated with this inquiry.			
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

SUBSCRIBER ELIGIBILITY OR BENEFIT ADDITIONAL INQUIRY INFORMATION

Loop: **2110C — SUBSCRIBER ELIGIBILITY OR BENEFIT INQUIRY INFORMATION**

Usage: **SITUATIONAL**

Repeat: **10**

Notes:

1. **Use this segment to identify Diagnosis codes and/or Facility Type as they relate to the information provided in the EQ segment.**
2. **Use the III segment when an information source supports or may be thought to support this level of functionality. If not supported, the information source will process without this segment.**
3. **Use this segment only one time for the Principal Diagnosis Code and only one time for Facility Type Code.**

Example: **III*BK*486~**
III*ZZ*21~

STANDARD

III Information

Level: Detail

Position: 170

Loop: 2110

Requirement: Optional

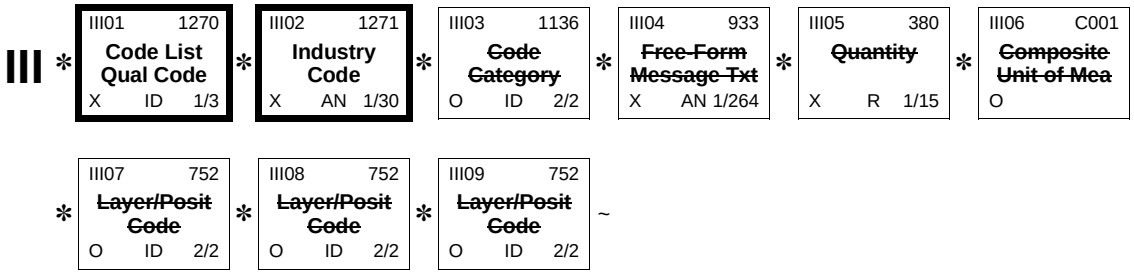
Max Use: 10

Purpose: To report information

Syntax:

1. **P0102**
   If either III01 or III02 is present, then the other is required.
2. **L030405**
   If III03 is present, then at least one of III04 or III05 are required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**III01**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list SYNTAX: P0102	**X**	**ID**	**1/3**

Use this code to specify if the code that is following in the III02 is a Principal Diagnosis Code, a Diagnosis Code or a Facility Type Code.

CODE	DEFINITION
BF	**Diagnosis**
	CODE SOURCE **131:** International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure
BK	**Principal Diagnosis**
	CODE SOURCE **131:** International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure
ZZ	**Mutually Defined** **Use this code for Facility Type Code.** **See Appendix C for Code Source 237, Place of Service from Health Care Financing Administration Claim Form.**

REQUIRED	**III02**	**1271**	**Industry Code** Code indicating a code from a specific industry code list SYNTAX: P0102 **If III01 is either BK or BF, use this element for diagnosis code from code source 131.** **If III01 is ZZ, use this element for codes identifying a place of service from code source 237. As a courtesy, the codes are listed below, however, the code list is thought to be complete at the time of publication of this implementation guideline. Since this list is subject to change, only codes contained in the document available from code source 237 are to be supported in this transaction and take precedence over any and all codes listed here.** **11 Office** **12 Home** **21 Inpatient Hospital** **22 Outpatient Hospital** **23 Emergency Room - Hospital** **24 Ambulatory Surgical Center** **25 Birthing Center** **26 Military Treatment Facility** **31 Skilled Nursing Facility** **32 Nursing Facility** **33 Custodial Care Facility** **34 Hospice** **41 Ambulance - Land** **42 Ambulance - Air or Water** **50 Federally Qualified Health Center** **51 Inpatient Psychiatric Facility** **52 Psychiatric Facility Partial Hospitalization** **53 Community Mental Health Center** **54 Intermediate Care Facility/Mentally Retarded** **55 Residential Substance Abuse Treatment Facility** **56 Psychiatric Residential Treatment Center** **60 Mass Immunization Center** **61 Comprehensive Inpatient Rehabilitation Facility** **62 Comprehensive Outpatient Rehabilitation Facility** **65 End-Stage Renal Disease Treatment Facility** **71 State or Local Public Health Clinic** **72 Rural Health Clinic** **81 Independent Laboratory** **99 Other Unlisted Facility**	**X**	**AN**	**1/30**
NOT USED	**III03**	**1136**	**Code Category**	**O**	**ID**	**2/2**
NOT USED	**III04**	**933**	**Free-Form Message Text**	**X**	**AN**	**1/264**
NOT USED	**III05**	**380**	**Quantity**	**X**	**R**	**1/15**
NOT USED	**III06**	**C001**	**COMPOSITE UNIT OF MEASURE**	**O**		
NOT USED	**III07**	**752**	**Surface/Layer/Position Code**	**O**	**ID**	**2/2**
NOT USED	**III08**	**752**	**Surface/Layer/Position Code**	**O**	**ID**	**2/2**
NOT USED	**III09**	**752**	**Surface/Layer/Position Code**	**O**	**ID**	**2/2**

IMPLEMENTATION

SUBSCRIBER ADDITIONAL INFORMATION

Loop: **2110C — SUBSCRIBER ELIGIBILITY OR BENEFIT INQUIRY INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Use this segment to identify referral or prior authorization numbers for the subscriber. The type of reference number is determined by the qualifier in REF01.**
2. **Use this segment when it is necessary to provide a referral or prior authorization number for the benefit being inquired about.**

Example: **REF*9F*660415~**

STANDARD

REF Reference Identification

Level: Detail

Position: 190

Loop: 2110

Requirement: Optional

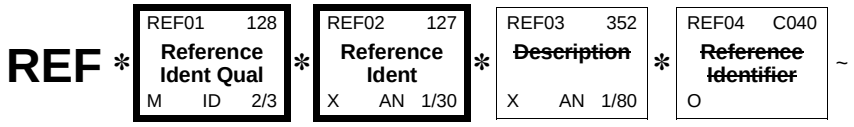
Max Use: 1

Purpose: To specify identifying information

Syntax:

1. **R0203**
   At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

Use this code to specify or qualify the type of reference number that is following in REF02, REF03, or both.

CODE	DEFINITION
9F	**Referral Number**
G1	**Prior Authorization Number**

REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Prior Authorization or Referral Number*** SYNTAX: R0203 **Use this reference number as qualified by the preceding data element (REF01).**	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

SUBSCRIBER ELIGIBILITY/BENEFIT DATE

Loop: **2110C — SUBSCRIBER ELIGIBILITY OR BENEFIT INQUIRY INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Use this segment to convey eligibility, admission, or service dates associated with the information contained in the corresponding EQ segment.**

2. **This segment is only to be used to override dates provided in Loop 2100C when the date differs from the date provided in the DTP segment in Loop 2100C. Dates that apply to the entire request should be placed in the DTP segment in Loop 2100C.**

Example: **DTP*472*D8*19940624~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 200

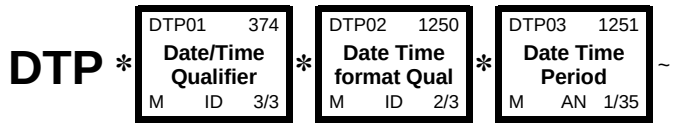
Loop: 2110

Requirement: Optional

Max Use: 9

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time	**M ID 3/3**

INDUSTRY: ***Date Time Qualifier***

CODE	DEFINITION
307	**Eligibility**
435	**Admission**
472	**Service**

REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier**	**M**	**ID**	**2/3**

Code indicating the date format, time format, or date and time format

SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03.

Use this code to specify the format of the date(s) or time(s) that follow in the next data element.

CODE	DEFINITION
D8	**Date Expressed in Format CCYYMMDD**
RD8	**Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD**

REQUIRED	**DTP03**	**1251**	**Date Time Period**	**M**	**AN**	**1/35**

Expression of a date, a time, or range of dates, times or dates and times

Use this date for the date(s) as qualified by the preceding data elements.

IMPLEMENTATION

DEPENDENT LEVEL

Loop: **2000D — DEPENDENT LEVEL** **Repeat:** **>1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Use the Dependent Level only if the patient is a dependent of a member and cannot be uniquely identified to the information source without the member's information in the Subscriber Level. If a patient is a dependent of a member, but can be uniquely identified to the information source (such as by, but not limited to, a unique Member Identification Number) then the patient is considered the subscriber and is to be identified in the Subscriber Level.**

2. **Because the usage of this segment is "Situational", this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 nomenclature.**

3. **Use this segment to identify the hierarchical or entity level of information being conveyed. The HL structure allows for the efficient nesting of related occurrences of information. The developers' intent is to clearly identify the relationship of the patient to the subscriber and the subscriber to the provider.**

   Additionally, multiple subscribers and/or dependents (i.e., the patient) can be grouped together under the same provider or the information for multiple providers or information receivers can be grouped together for the same payer or information source.

4. **An example of the overall structure of the transaction set when used in batch mode is:**

   Information Source (Loop 2000A)
   Information Receiver (Loop 2000B)
   Subscriber (Loop 2000C)
   Dependent (Loop 2000D)
   Eligibility or Benefit Inquiry
   Dependent (Loop 2000D)
   Eligibility or Benefit Inquiry
   Subscriber (Loop 2000C)
   Eligibility or Benefit Inquiry

Example: **HL*4*3*23*0~**

STANDARD

HL Hierarchical Level

Level: Detail

Position: 010

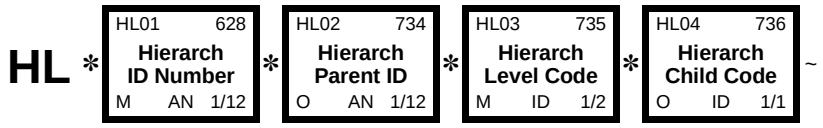
Loop: 2000 **Repeat:** >1

Requirement: Mandatory

Max Use: 1

Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES

REQUIRED **HL01** **628** **Hierarchical ID Number** **M AN 1/12**

A unique number assigned by the sender to identify a particular data segment in a hierarchical structure

COMMENT: HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.

Use this sequentially assigned positive number to identify each specific occurrence of an HL segment within a transaction set. It should begin with the number one and be incremented by one for each successive occurrence of the HL segment within that specific transaction set (ST through SE).

An example of the use of the HL segment and this data element is:

```
HL*1**20*1~
NM1*PR*2*ABC INSURANCE COMPANY*****PI*842610001~
HL*2*1*21*1~
NM1*1P*1*JONES*MARCUS***MD*SV*0202034~
HL*3*2*22*1~
NM1*IL*1*SMITH*ROBERT*B***MI*11122333301~
HL*4*3*23*0~
NM1*03*1*SMITH*MARY*LOU~
  Eligibility/Benefit Data
HL*5*2*22*0~
NM1*IL*1*BROWN*JOHN*E***MI*22211333301~
  Eligibility/Benefit Data
```

An example of the use of the HL segment and this data element is:

```
HL*1**20*1~
NM1*PR*2*ABC INSURANCE COMPANY*****PI*842610001~
HL*2*1*21*1~
NM1*1P*1*JONES*MARCUS***MD*SV*0202034~
HL*3*2*22*1~
NM1*IL*1*SMITH*ROBERT*B***MI*11122333301~
HL*4*3*23*0~
NM1*03*1*SMITH*MARY*LOU~
  Eligibility/Benefit Data
HL*5*2*22*0~
NM1*IL*1*BROWN*JOHN*E***MI*22211333301~
  Eligibility/Benefit Data
```

REQUIRED **HL02** **734** **Hierarchical Parent ID Number** **O AN 1/12**

Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to

COMMENT: HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.

Use this code to identify the specific hierarchical level to which this level is subordinate.

REQUIRED **HL03** **735** **Hierarchical Level Code** **M ID 1/2**
Code defining the characteristic of a level in a hierarchical structure

COMMENT: HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information.

All data that follows an HL segment is associated with the entity identified by the level code; this association continues until the next occurrence of an HL segment.

CODE	DEFINITION
23	**Dependent**

REQUIRED **HL04** **736** **Hierarchical Child Code** **O ID 1/1**
Code indicating if there are hierarchical child data segments subordinate to the level being described

COMMENT: HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

Use this code to indicate whether there are additional hierarchical levels subordinate to the current hierarchical level.

Because of the hierarchical structure, and because no HL level is subordinate to this level, the code value in the HL04 at the Loop 2000D level should always be "0" (zero).

CODE	DEFINITION
0	**No Subordinate HL Segment in This Hierarchical Structure.**

IMPLEMENTATION

DEPENDENT TRACE NUMBER

Loop: **2000D — DEPENDENT LEVEL**

Usage: **SITUATIONAL**

Repeat: **2**

Notes:

1. **Trace numbers assigned at the dependent level are intended to allow tracing of an eligibility/benefit transaction when the dependent is the patient.**

2. **The information receiver may assign one TRN segment in this loop if the dependent is the patient. A clearinghouse may assign one TRN segment in this loop if the dependent is the patient. See Section 1.3.6 Information Linkage.**

Example: **TRN*1*98175-012547*9877281234*RADIOLOGY~**
TRN*1*109834652831*9XYZCLEARH*REALTIME~

STANDARD

TRN Trace

Level: Detail

Position: 020

Loop: 2000

Requirement: Optional

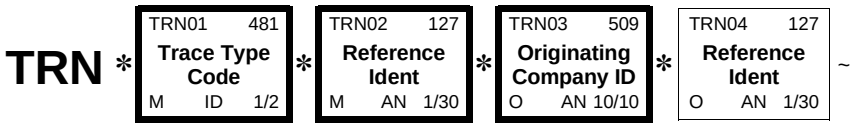
Max Use: 9

Purpose: To uniquely identify a transaction to an application

Set Notes:

1. If the Eligibility, Coverage or Benefit Inquiry Transaction Set (270) includes a TRN segment, then the Eligibility, Coverage or Benefit Information Transaction Set (271) must return the trace number identified in the TRN segment.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**TRN01**	**481**	**Trace Type Code** Code identifying which transaction is being referenced	**M ID 1/2**

CODE	DEFINITION
1	**Current Transaction Trace Numbers**

REQUIRED	**TRN02**	**127**	**Reference Identification**	**M**	**AN**	**1/30**

Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

INDUSTRY: ***Trace Number***

SEMANTIC: TRN02 provides unique identification for the transaction.

Use this number for the trace or reference number assigned by the information receiver.

REQUIRED	**TRN03**	**509**	**Originating Company Identifier**	**O**	**AN**	**10/10**

A unique identifier designating the company initiating the funds transfer instructions. The first character is one-digit ANSI identification code designation (ICD) followed by the nine-digit identification number which may be an IRS employer identification number (EIN), data universal numbering system (DUNS), or a user assigned number; the ICD for an EIN is 1, DUNS is 3, user assigned number is 9

INDUSTRY: ***Trace Assigning Entity Identifier***

SEMANTIC: TRN03 identifies an organization.

Use this number for the identification number of the company that assigned the trace or reference number specified in the previous data element (TRN02).

The first position must be either a “1" if an EIN is used, a ”3" if a DUNS is used or a “9" if a user assigned identifier is used.

SITUATIONAL	**TRN04**	**127**	**Reference Identification**	**O**	**AN**	**1/30**

Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

INDUSTRY: ***Trace Assigning Entity Additional Identifier***

SEMANTIC: TRN04 identifies a further subdivision within the organization.

Use this information if necessary to further identify a specific component of the company identified in the previous data element (TRN03). This information allows the originating company to further identify a specific division or group within that organization that was responsible for assigning the trace or reference number.

IMPLEMENTATION

DEPENDENT NAME

Loop: **2100D — DEPENDENT NAME** **Repeat:** **1**

Usage: **REQUIRED**

Repeat: **1**

Notes:

1. **Use this segment to identify an entity by name. This NM1 loop is used to identify the dependent of an insured or subscriber.**
2. **Please refer to Section 1.3.8 Search Options for specific information about how to identify an individual to an Information Source.**

Example: **NM1*03*1*SMITH*MARY LOU*R~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 030

Loop: 2100 **Repeat:** >1

Requirement: Mandatory

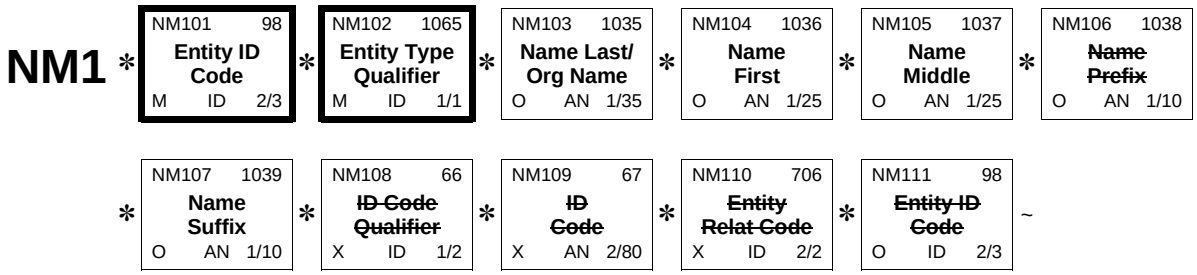
Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M ID 2/3**

CODE	DEFINITION
03	**Dependent**

REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103. **Use this code to indicate whether the entity is an individual person or an organization.** CODE / DEFINITION **1 Person**	**M**	**ID**	**1/1**
SITUATIONAL	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name ***INDUSTRY:* *Dependent Last Name*** **Use this name for the dependent's last name.** **Use this element if utilizing the HIPAA search option. See Section 1.3.8 for more information.**	**O**	**AN**	**1/35**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name ***INDUSTRY:* *Dependent First Name*** **Use this name for the dependent's first name.** **Use this element if utilizing the HIPAA search option. See Section 1.3.8 for more information.**	**O**	**AN**	**1/25**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial ***INDUSTRY:* *Dependent Middle Name*** **Use this name for the dependent's middle name or initial. Use if information is known and will assist in identification of the person named, particularly when not utilizing the HIPAA search option.**	**O**	**AN**	**1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**AN**	**1/10**
SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name ***INDUSTRY:* *Dependent Name Suffix*** **Use this for the suffix to an individual's name; e.g., Sr., Jr. or III. Use if information is known and will assist in identification of the person named, particularly when not utilizing the HIPAA search option.**	**O**	**AN**	**1/10**
NOT USED	**NM108**	**66**	**Identification Code Qualifier**	**X**	**ID**	**1/2**
NOT USED	**NM109**	**67**	**Identification Code**	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

DEPENDENT ADDITIONAL IDENTIFICATION

Loop: **2100D — DEPENDENT NAME**

Usage: **SITUATIONAL**

Repeat: **9**

Notes:

1. **Use this segment when needed to convey identification numbers for the dependent. The type of reference number is determined by the qualifier in REF01.**
2. **Please refer to Section 1.3.8 Search Options for specific information about how to identify an individual to an Information Source.**

Example: **REF*1L*660415~**

STANDARD

REF Reference Identification

Level: Detail

Position: 040

Loop: 2100

Requirement: Optional

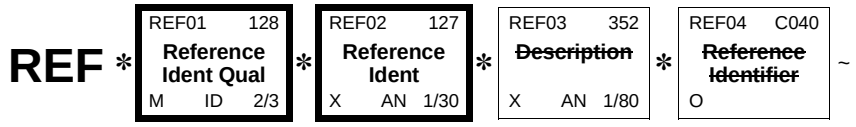
Max Use: 9

Purpose: To specify identifying information

Syntax:

1. **R0203**
   At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

Use this code to specify or qualify the type of reference number that is following in REF02, REF03, or both.

CODE	DEFINITION
18	**Plan Number**
1L	**Group or Policy Number** **Use this code only if it cannot be determined if the number is a Group Number or a Policy number. Use codes "IG" or "6P" when they can be determined.**

			6P	**Group Number**			
			A6	**Employee Identification Number**			
			CT	**Contract Number** **This code is to be used only to identify the provider's contract number of the provider identified in the PRV segment of Loop 2100D. This code is only to be used once the HCFA National Provider Identifier has been mandated for use, and must be sent if required in the contract between the Information Receiver identified in Loop 2100B and the Information Source identified in Loop 2100A.**			
			EA	**Medical Record Identification Number**			
			EJ	**Patient Account Number**			
			F6	**Health Insurance Claim (HIC) Number**			
			GH	**Identification Card Serial Number** **Use this code when the Identification Card has a number in addition to the Member Identification Number or Identity Card Number. The Identification Card Serial Number uniquely identifies the card when multiple cards have been or will be issued to a member (e.g., on a monthly basis, replacement cards). This is particularly prevalent in the Medicaid environment.**			
			HJ	**Identity Card Number** **Use this code when the Identity Card Number is different than the Member Identification Number. This is particularly prevalent in the Medicaid environment.**			
			IF	**Issue Number**			
			IG	**Insurance Policy Number**			
			N6	**Plan Network Identification Number**			
			SY	**Social Security Number** **The social security number may not be used for any Federally administered programs such as Medicare.**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Dependent Supplemental Identifier*** SYNTAX: R0203 **Use this reference number as qualified by the preceding data element (REF01).**	**X**	**AN**	**1/30**	
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**	
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**			

IMPLEMENTATION

DEPENDENT ADDRESS

Loop: **2100D — DEPENDENT NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Use this segment when needed to convey the address information for the dependent. Use if information is known and will assist in identification of the person named, particularly when not utilizing the HIPAA search option.**

Example: **N3*15197 BROADWAY AVENUE*APT 215~**

STANDARD

N3 Address Information

Level: Detail

Position: 060

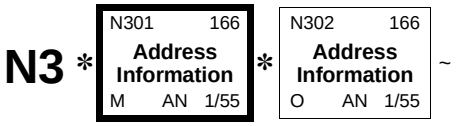
Loop: 2100

Requirement: Optional

Max Use: 1

Purpose: To specify the location of the named party

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N301**	**166**	**Address Information** Address information	**M**	**AN**	**1/55**
			INDUSTRY: ***Dependent Address Line***			
			Use this information for the first line of the address information.			
SITUATIONAL	**N302**	**166**	**Address Information** Address information	**O**	**AN**	**1/55**
			INDUSTRY: ***Dependent Address Line***			
			Use this information for the second line of the address information.			
			Required if a second address line exists.			

IMPLEMENTATION

DEPENDENT CITY/STATE/ZIP CODE

Loop: **2100D — DEPENDENT NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Use this segment when needed to convey the city, state, and ZIP code for the dependent. Use if information is known and will assist in identification of the person named, particularly when not utilizing the HIPAA search option.**

Example: **N4✻NEW YORK✻NY✻10003~**

STANDARD

N4 Geographic Location

Level: Detail

Position: 070

Loop: 2100

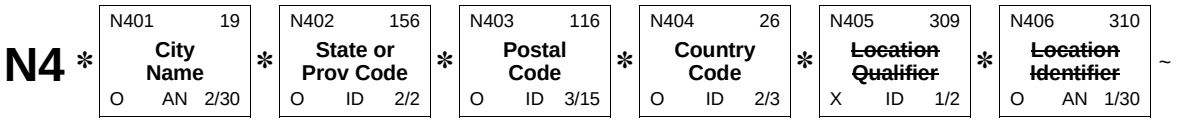
Requirement: Optional

Max Use: 1

Purpose: To specify the geographic place of the named party

Syntax: **1. C0605**
If N406 is present, then N405 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**N401**	**19**	**City Name** Free-form text for city name *INDUSTRY:* ***Dependent City Name*** COMMENT: A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location. **Use this text for the city name of the dependent's address.**	**O AN 2/30**

SITUATIONAL	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency	**O**	**ID**	**2/2**
			INDUSTRY: ***Dependent State Code***			
			COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada.			
			CODE SOURCE 22: States and Outlying Areas of the U.S.			
			Use this code for the state code of the dependent's address.			
SITUATIONAL	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States)	**O**	**ID**	**3/15**
			INDUSTRY: ***Dependent Postal Zone or ZIP Code***			
			CODE SOURCE 51: ZIP Code			
			Use this code for the ZIP or Postal Code of the dependent's address.			
SITUATIONAL	**N404**	**26**	**Country Code** Code identifying the country	**O**	**ID**	**2/3**
			CODE SOURCE 5: Countries, Currencies and Funds			
			Use this code to specify the country of the dependent's address, if other than the United States.			
NOT USED	**N405**	**309**	**Location Qualifier**	**X**	**ID**	**1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O**	**AN**	**1/30**

IMPLEMENTATION

PROVIDER INFORMATION

Loop: **2100D — DEPENDENT NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Use this segment when needed to either identify a specific provider or associate a specialty type related to the service identified in the 2110D loop.**
2. **If identifying a specific provider, use this segment to convey specific information about a provider's role in the eligibility/benefit being inquired about when the provider is not the information receiver. For example, if the information receiver is a hospital and a referring provider must be identified, this is the segment where the referring provider would be identified.**
3. **If identifying a specific provider, this segment contains reference identification numbers, all of which may be used up until the time the National Provider Identifier (NPI) is mandated for use. After the NPI is mandated, only the code for National Provider Identifier may be used.**
4. **If identifying a type of specialty associated with the services identified in loop 2110D, use code ZZ in PRV02 and the appropriate code in PRV03.**
5. **PRV02 qualifies PRV03.**

Example: **PRV*PE*EI*9991234567~**
PRV*PE*ZZ*203BA0504N~

STANDARD

PRV Provider Information

Level: Detail

Position: 090

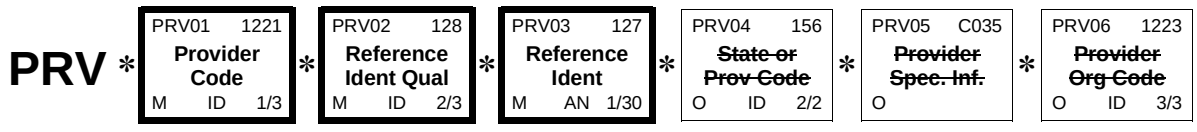
Loop: 2100

Requirement: Optional

Max Use: 1

Purpose: To specify the identifying characteristics of a provider

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	PRV01	1221	**Provider Code** Code indentifying the type of provider	M	ID	1/3

CODE	DEFINITION
AD	Admitting
AT	Attending
BI	Billing
CO	Consulting
CV	Covering
H	Hospital
HH	Home Health Care
LA	Laboratory
OT	Other Physician
P1	Pharmacist
P2	Pharmacy
PC	Primary Care Physician
PE	Performing
R	Rural Health Clinic
RF	Referring
SB	Submitting
SK	Skilled Nursing Facility
SU	Supervising

REQUIRED	**PRV02**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M**	**ID**	**2/3**

If this segment is used to identify a specific provider and the National Provider ID is mandated for use, code value "HPI" must be used, otherwise one of the other code values may be used.

If this segment is used to identify a type of specialty associated with the services identified in loop 2110D, use code ZZ. ZZ is used to indicate the "Health Care Provider Taxonomy" code list (provider specialty code) which is available on the Washington Publishing Company web site: http://www.wpc-edi.com. This taxonomy is maintained by the Blue Cross Blue Shield Association and ASC X12N TG2 WG15.

CODE	DEFINITION
9K	**Servicer** **Use this code for the identification number assigned by the information source to be used by the information receiver in health care transactions.**
D3	**National Association of Boards of Pharmacy Number** CODE SOURCE **307:** National Association of Boards of Pharmacy Number
EI	**Employer's Identification Number**
HPI	**Health Care Financing Administration National Provider Identifier** **Required value when identifying a specific provider when the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.** CODE SOURCE **537:** Health Care Financing Administration National Provider Identifier
SY	**Social Security Number** **The social security number may not be used for any Federally administered programs such as Medicare.**
TJ	**Federal Taxpayer's Identification Number**
ZZ	**Mutually Defined** **Health Care Provider Taxonomy Code list.**

REQUIRED	**PRV03**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**M**	**AN**	**1/30**

INDUSTRY: ***Provider Identifier***

Use this number for the reference number as qualified by the preceding data element (PRV02).

NOT USED	**PRV04**	**156**	**State or Province Code**	**O**	**ID**	**2/2**
NOT USED	**PRV05**	**C035**	**PROVIDER SPECIALTY INFORMATION**	**O**		
NOT USED	**PRV06**	**1223**	**Provider Organization Code**	**O**	**ID**	**3/3**

IMPLEMENTATION

DEPENDENT DEMOGRAPHIC INFORMATION

Loop: **2100D — DEPENDENT NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Use this segment when needed to convey the birth date or gender demographic information for the dependent.**
2. **Please refer to Section 1.3.8 Search Options for specific information about how to identify an individual to an Information Source.**

Example: **DMG*D8*19430121*F~**

STANDARD

DMG Demographic Information

Level: Detail

Position: 100

Loop: 2100

Requirement: Optional

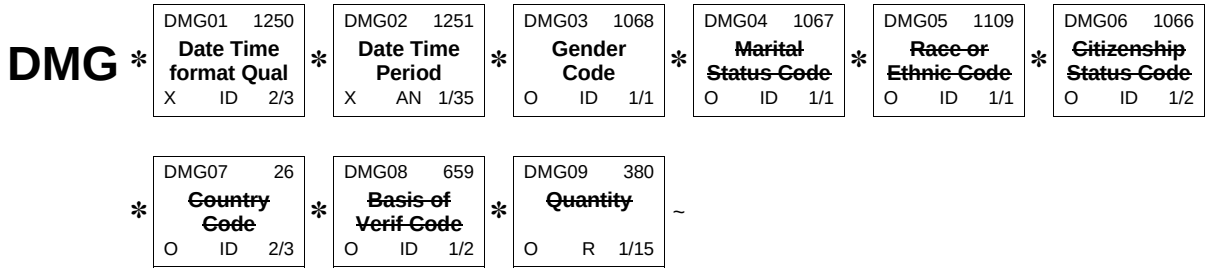
Max Use: 1

Purpose: To supply demographic information

Syntax:

1. **P0102**
   If either DMG01 or DMG02 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	DMG01	1250	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format SYNTAX: P0102 **Use this code to indicate the format of the date of birth that follows in DMG02.** **Use this element if utilizing the HIPAA search option. See Section 1.3.8 for more information.** CODE — DEFINITION D8 — Date Expressed in Format CCYYMMDD	X ID 2/3
SITUATIONAL	DMG02	1251	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times *INDUSTRY:* ***Dependent Birth Date*** SYNTAX: P0102 SEMANTIC: DMG02 is the date of birth. **Use this date for the date of birth of the individual.** **Use this element if utilizing the HIPAA search option. See Section 1.3.8 for more information.**	X AN 1/35
SITUATIONAL	DMG03	1068	**Gender Code** Code indicating the sex of the individual *INDUSTRY:* ***Dependent Gender Code*** **Use this code to indicate the dependent's gender.** **Use if information is known and will assist in identification of the person named, particularly when not utilizing the HIPAA search option.** CODE — DEFINITION F — Female M — Male	O ID 1/1
NOT USED	DMG04	1067	**Marital Status Code**	O ID 1/1
NOT USED	DMG05	1109	**Race or Ethnicity Code**	O ID 1/1
NOT USED	DMG06	1066	**Citizenship Status Code**	O ID 1/2
NOT USED	DMG07	26	**Country Code**	O ID 2/3
NOT USED	DMG08	659	**Basis of Verification Code**	O ID 1/2
NOT USED	DMG09	380	**Quantity**	O R 1/15

IMPLEMENTATION

DEPENDENT RELATIONSHIP

Loop: **2100D — DEPENDENT NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Use this segment only in the absence of all of the data for the mandated search option identified in Section 1.3.8. Use only if it is necessary to identify the dependent's relationship to the subscriber identified in loop 2100C or the dependent's birth sequence in the case of multiple births with the same birth date.**

2. **Different types of health plans identify patients in different manners depending upon how their eligibility is structured. However, two approaches predominate.**

   The first approach is to assign each member of the family (and plan) a unique ID number. This number can be used to identify and access that individual's information independent of whether he or she is a child, spouse, or the actual subscriber to the plan. The relationship of this individual to the actual subscriber or contract holder would be one of spouse, child, self, etc.

   The second approach is to assign the actual subscriber or contract holder a unique ID number that is entered into the eligibility system. Any related spouse, children, or dependents are identified through the subscriber's ID and have no unique identification number of their own. In this approach, the subscriber would be identified at the Loop 2100C subscriber or insured level and the actual patient (spouse, child, etc.) would be identified at the Loop 2100D dependent level under the subscriber.

Example: **INS*N*01~**

STANDARD

INS Insured Benefit

Level: Detail

Position: 110

Loop: 2100

Requirement: Optional

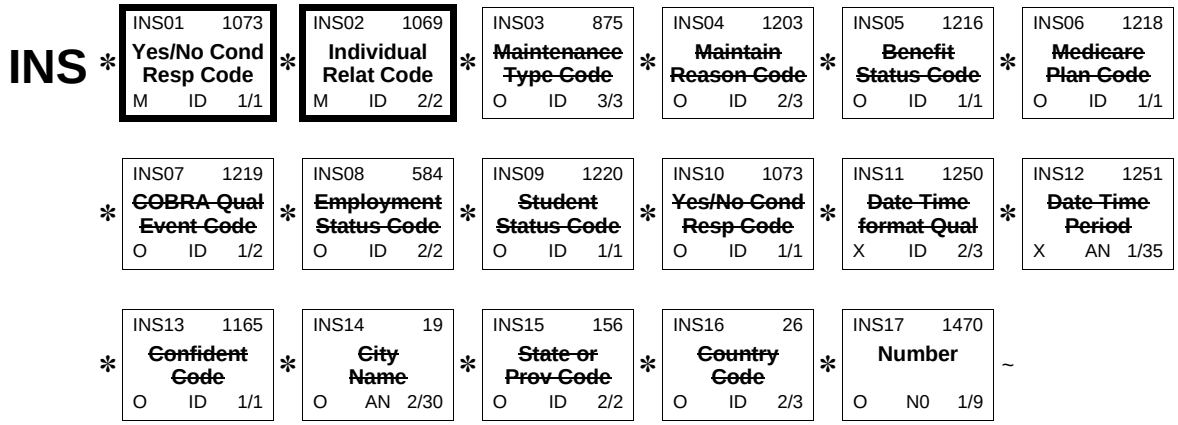
Max Use: 1

Purpose: To provide benefit information on insured entities

Syntax:

1. **P1112**
   If either INS11 or INS12 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**INS01**	**1073**	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response *INDUSTRY:* ***Insured Indicator*** **SEMANTIC:** INS01 indicates status of the insured. A "Y" value indicates the insured is a subscriber: an "N" value indicates the insured is a dependent. **N** = **No**	**M**	**ID**	**1/1**
REQUIRED	**INS02**	**1069**	**Individual Relationship Code** Code indicating the relationship between two individuals or entities **01** = **Spouse** **19** = **Child** **34** = **Other Adult**	**M**	**ID**	**2/2**
NOT USED	**INS03**	**875**	**Maintenance Type Code**	**O**	**ID**	**3/3**
NOT USED	**INS04**	**1203**	**Maintenance Reason Code**	**O**	**ID**	**2/3**
NOT USED	**INS05**	**1216**	**Benefit Status Code**	**O**	**ID**	**1/1**
NOT USED	**INS06**	**1218**	**Medicare Plan Code**	**O**	**ID**	**1/1**
NOT USED	**INS07**	**1219**	**Consolidated Omnibus Budget Reconciliation Act (COBRA) Qualifying**	**O**	**ID**	**1/2**
NOT USED	**INS08**	**584**	**Employment Status Code**	**O**	**ID**	**2/2**
NOT USED	**INS09**	**1220**	**Student Status Code**	**O**	**ID**	**1/1**
NOT USED	**INS10**	**1073**	**Yes/No Condition or Response Code**	**O**	**ID**	**1/1**
NOT USED	**INS11**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**INS12**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**INS13**	**1165**	**Confidentiality Code**	**O**	**ID**	**1/1**

NOT USED	INS14	19	City Name	O	AN	2/30
NOT USED	INS15	156	State or Province Code	O	ID	2/2
NOT USED	INS16	26	Country Code	O	ID	2/3
SITUATIONAL	INS17	1470	Number A generic number	O	N0	1/9

INDUSTRY: ***Birth Sequence Number***

SEMANTIC: INS17 is the number assigned to each family member born with the same birth date. This number identifies birth sequence for multiple births allowing proper tracking and response of benefits for each dependent (i.e., twins, triplets, etc.).

Use to indicate the birth order in the event of multiple birth's in association with the birth date supplied in DMG02.

IMPLEMENTATION

DEPENDENT DATE

Loop: **2100D — DEPENDENT NAME**

Usage: **SITUATIONAL**

Repeat: **2**

Notes:

1. **Use this segment to convey the eligibility, service or admission date(s) for the subscriber or for the issue date of the subscriber's identification card for the information source (e.g., Medicaid ID card). Absence of an Eligibility, Admission or Service date implies the request is for the date the transaction is processed.**

2. **When using codes "307" (Eligibility), "435" (Admission) or "472" (Service) at this level, it is implied that these dates apply to all of the Eligibility or Benefit Inquiry (EQ) loops that follow. If there is a need to supply a different Eligibility, Admission or Service date for a specific EQ loop, it must be provided in the DTP segment within the EQ loop and it will only apply to that EQ loop.**

Example: **DTP*102*D8*19950818~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 120

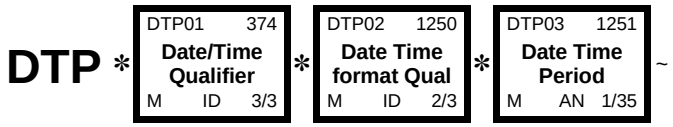
Loop: 2100

Requirement: Optional

Max Use: 9

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time *INDUSTRY:* ***Date Time Qualifier*** **Only one of the following codes may be used per request: 307 - Eligibility, 435 - Admission or 472 - Service.**	**M ID 3/3**
			CODE / **DEFINITION** **102** — **Issue** **Used if utilizing a search option other than the HIPAA search option identified in section 1.3.8 and is present on the identification card and is available.** **307** — **Eligibility** **435** — **Admission** **472** — **Service**	
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **SEMANTIC:** DTP02 is the date or time or period format that will appear in DTP03. **Use this code to specify the format of the date(s) or time(s) that follow in the next data element.**	**M ID 2/3**
			CODE / **DEFINITION** **D8** — **Date Expressed in Format CCYYMMDD** **RD8** — **Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD**	
REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times **Use this date for the date(s) as qualified by the preceding data elements.**	**M AN 1/35**

IMPLEMENTATION

DEPENDENT ELIGIBILITY OR BENEFIT INQUIRY INFORMATION

Loop: **2110D — DEPENDENT ELIGIBILITY OR BENEFIT INQUIRY INFORMATION Repeat: 99**

Usage: **REQUIRED**

Repeat: **1**

Notes:

1. **Use this segment to begin the eligibility/benefit inquiry looping structure.**

2. **If the EQ segment is used, either EQ01 - Service Type Code or EQ02 - Composite Medical Procedure Identifier must be used. Only EQ01 or EQ02 is to be sent, not both.**

   An information source must support a generic request for Eligibility. This is accomplished by submitting a Service Type Code of "30" (Health Benefit Plan Coverage) in EQ01. An information source may support the use of Service Type Codes other than "30" (Health Benefit Plan Coverage) in EQ01 at their discretion.

   An information source may support the use of EQ02 - Composite Medical Procedure Identifier at their discretion. The EQ02 allows for a very specific inquiry, such as one based on a procedure code. Additional information such as diagnosis codes and place of service can be supplied in the III segment of loop 2100D.

3. **If an inquiry is submitted with either a Service Type Code other than "30" in EQ01 or uses EQ02 and the information source does not support either of these levels of functionality, a generic response will be returned. The generic response will be the same response as if a Service Type Code of "30" (Health Benefit Plan Coverage) was received by the information source. Refer to Section 1.3.6 for additional information.**

Example: **EQ*30**FAM*GP~**

STANDARD

EQ Eligibility or Benefit Inquiry

Level: Detail

Position: 130

Loop: 2110 **Repeat:** 99

Requirement: Optional

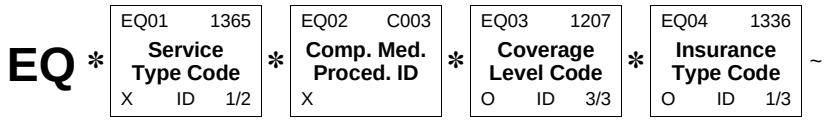
Max Use: 1

Purpose: To specify inquired eligibility or benefit information

Syntax:

1. **R0102**
   At least one of EQ01 or EQ02 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	EQ01	1365	**Service Type Code** Code identifying the classification of service SYNTAX: R0102	X ID 1/2

An information source must support a generic request for Eligibility. This is accomplished by submitting a Service Type Code of "30" (Health Benefit Plan Coverage) in EQ01.

An information source may support the use of Service Type Codes from the list other than "30" (Health Benefit Plan Coverage) in EQ01 at their discretion. If an information source supports codes in addition to "30", the information source may provide a list of the supported codes from the list below to the information receiver. If no list is provided, an information receiver may transmit the most appropriate code.

If an inquiry is submitted with a Service Type Code from the list other than "30" and the information source does not support this level of functionality, a generic response will be returned. The generic response will be the same response as if a Service Type Code of "30" (Health Benefit Plan Coverage) was received by the information source. Refer to Section 1.3.6 for additional information.

Not used if EQ02 is used.

CODE	DEFINITION
1	Medical Care
2	Surgical
3	Consultation
4	Diagnostic X-Ray
5	Diagnostic Lab
6	Radiation Therapy
7	Anesthesia
8	Surgical Assistance
9	Other Medical
10	Blood Charges
11	Used Durable Medical Equipment

12	Durable Medical Equipment Purchase
13	Ambulatory Service Center Facility
14	Renal Supplies in the Home
15	Alternate Method Dialysis
16	Chronic Renal Disease (CRD) Equipment
17	Pre-Admission Testing
18	Durable Medical Equipment Rental
19	Pneumonia Vaccine
20	Second Surgical Opinion
21	Third Surgical Opinion
22	Social Work
23	Diagnostic Dental
24	Periodontics
25	Restorative
26	Endodontics
27	Maxillofacial Prosthetics
28	Adjunctive Dental Services
30	Health Benefit Plan Coverage If only a single category of inquiry can be supported, use this code.
32	Plan Waiting Period
33	Chiropractic
34	Chiropractic Office Visits
35	Dental Care
36	Dental Crowns
37	Dental Accident
38	Orthodontics
39	Prosthodontics
40	Oral Surgery
41	Routine (Preventive) Dental
42	Home Health Care
43	Home Health Prescriptions
44	Home Health Visits

45	Hospice
46	Respite Care
47	Hospital
48	Hospital - Inpatient
49	Hospital - Room and Board
50	Hospital - Outpatient
51	Hospital - Emergency Accident
52	Hospital - Emergency Medical
53	Hospital - Ambulatory Surgical
54	Long Term Care
55	Major Medical
56	Medically Related Transportation
57	Air Transportation
58	Cabulance
59	Licensed Ambulance
60	General Benefits
61	In-vitro Fertilization
62	MRI/CAT Scan
63	Donor Procedures
64	Acupuncture
65	Newborn Care
66	Pathology
67	Smoking Cessation
68	Well Baby Care
69	Maternity
70	Transplants
71	Audiology Exam
72	Inhalation Therapy
73	Diagnostic Medical
74	Private Duty Nursing
75	Prosthetic Device

76	Dialysis
77	Otological Exam
78	Chemotherapy
79	Allergy Testing
80	Immunizations
81	Routine Physical
82	Family Planning
83	Infertility
84	Abortion
85	AIDS
86	Emergency Services
87	Cancer
88	Pharmacy
89	Free Standing Prescription Drug
90	Mail Order Prescription Drug
91	Brand Name Prescription Drug
92	Generic Prescription Drug
93	Podiatry
94	Podiatry - Office Visits
95	Podiatry - Nursing Home Visits
96	Professional (Physician)
97	Anesthesiologist
98	Professional (Physician) Visit - Office
99	Professional (Physician) Visit - Inpatient
A0	Professional (Physician) Visit - Outpatient
A1	Professional (Physician) Visit - Nursing Home
A2	Professional (Physician) Visit - Skilled Nursing Facility
A3	Professional (Physician) Visit - Home
A4	Psychiatric
A5	Psychiatric - Room and Board
A6	Psychotherapy

A7	Psychiatric - Inpatient
A8	Psychiatric - Outpatient
A9	Rehabilitation
AA	Rehabilitation - Room and Board
AB	Rehabilitation - Inpatient
AC	Rehabilitation - Outpatient
AD	Occupational Therapy
AE	Physical Medicine
AF	Speech Therapy
AG	Skilled Nursing Care
AH	Skilled Nursing Care - Room and Board
AI	Substance Abuse
AJ	Alcoholism
AK	Drug Addiction
AL	Vision (Optometry)
AM	Frames
AN	Routine Exam
AO	Lenses
AQ	Nonmedically Necessary Physical
AR	Experimental Drug Therapy
BA	Independent Medical Evaluation
BB	Partial Hospitalization (Psychiatric)
BC	Day Care (Psychiatric)
BD	Cognitive Therapy
BE	Massage Therapy
BF	Pulmonary Rehabilitation
BG	Cardiac Rehabilitation
BH	Pediatric
BI	Nursery
BJ	Skin
BK	Orthopedic
BL	Cardiac

BM	**Lymphatic**
BN	**Gastrointestinal**
BP	**Endocrine**
BQ	**Neurology**
BR	**Eye**
BS	**Invasive Procedures**

SITUATIONAL **EQ02** **C003** **COMPOSITE MEDICAL PROCEDURE IDENTIFIER** **X**

To identify a medical procedure by its standardized codes and applicable modifiers

An information source may support the use of EQ02 - Composite Medical Procedure Identifier at their discretion. The EQ02 allows for a very specific inquiry, such as one based on a procedure code. Additional information such as diagnosis codes and place of service can be supplied in the III segment of loop 2110D.

If an inquiry is submitted with EQ02 and the information source does not support this level of functionality, a generic response will be returned. The generic response will be the same response as if a Service Type Code of "30" (Health Benefit Plan Coverage) was received by the information source. Refer to Section 1.3.6 for additional information.

Not used if EQ01 is used.

REQUIRED **EQ02 - 1** **235** **Product/Service ID Qualifier** **M** **ID** **2/2**

Code identifying the type/source of the descriptive number used in Product/Service ID (234)

INDUSTRY: ***Product or Service ID Qualifier***

Use this code to qualify the type of specific Product/Service ID that will be used in EQ02-2.

CODE	DEFINITION
AD	**American Dental Association Codes**
	CODE SOURCE 135: American Dental Association Codes
CJ	**Current Procedural Terminology (CPT) Codes**
	CODE SOURCE 133: Current Procedural Terminology (CPT) Codes
HC	**Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes**
	CODE SOURCE 130: Health Care Financing Administration Common Procedural Coding System
ID	**International Classification of Diseases Clinical Modification (ICD-9-CM) - Procedure**
	CODE SOURCE 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure
IV	**Home Infusion EDI Coalition (HIEC) Product/Service Code**
	CODE SOURCE 513: Home Infusion EDI Coalition (HIEC) Product/Service Code List

		ND	**National Drug Code (NDC)** CODE SOURCE **134:** National Drug Code			
		ZZ	**Mutually Defined** **NOT ADVISED** **Use this code only for local codes or interim uses until an appropriate new code is approved.**			
REQUIRED	**EQ02 - 2**	**234**	**Product/Service ID** Identifying number for a product or service *INDUSTRY:* ***Procedure Code*** **Use this number for the product/service ID as identified by the preceding data element (EQ02-1).**	**M**	**AN**	**1/48**
SITUATIONAL	**EQ02 - 3**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners **Used when an information source supports or may be thought to support this high level of functionality if modifiers are required to further specify the service. If not supported, information source will process without this data element.**	**O**	**AN**	**2/2**
SITUATIONAL	**EQ02 - 4**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners **Used when an information source supports or may be thought to support this high level of functionality if modifiers are required to further specify the service. If not supported, information source will process without this data element.**	**O**	**AN**	**2/2**
SITUATIONAL	**EQ02 - 5**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners **Used when an information source supports or may be thought to support this high level of functionality if modifiers are required to further specify the service. If not supported, information source will process without this data element.**	**O**	**AN**	**2/2**
SITUATIONAL	**EQ02 - 6**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners **Used when an information source supports or may be thought to support this high level of functionality if modifiers are required to further specify the service. If not supported, information source will process without this data element.**	**O**	**AN**	**2/2**
NOT USED	**EQ02 - 7**	**352**	**Description**	**O**	**AN**	**1/80**

SITUATIONAL **EQ03** **1207** **Coverage Level Code** **O** **ID** **3/3**
Code indicating the level of coverage being provided for this insured

INDUSTRY: ***Benefit Coverage Level Code***

Use EQ03 when an information source supports or may be thought to support the function of identifying benefits by the Benefit Coverage Level Code. Use this code to identify the types and number of entities that the request is to apply to. If not supported, the information source will process without this data element.

CODE	DEFINITION
CHD	Children Only
DEP	Dependents Only
ECH	Employee and Children
EMP	Employee Only
ESP	Employee and Spouse
FAM	Family
IND	Individual
SPC	Spouse and Children
SPO	Spouse Only

SITUATIONAL **EQ04** **1336** **Insurance Type Code** **O** **ID** **1/3**
Code identifying the type of insurance policy within a specific insurance program

Use this code to identify the specific type of insurance the inquiry applies to if the information source has multiple insurance lines that apply to the person being inquired about. Do not use if the insurance type can be determined either by the person's identifiers or the information source's identifiers.

CODE	DEFINITION
AP	Auto Insurance Policy
C1	Commercial
CO	Consolidated Omnibus Budget Reconciliation Act (COBRA)
GP	Group Policy
HM	Health Maintenance Organization (HMO)
IP	Individual Policy
OT	Other
PR	Preferred Provider Organization (PPO)
PS	Point of Service (POS)
SP	Supplemental Policy
WC	Workers Compensation

IMPLEMENTATION

DEPENDENT ELIGIBILITY OR BENEFIT ADDITIONAL INQUIRY INFORMATION

Loop: **2110D — DEPENDENT ELIGIBILITY OR BENEFIT INQUIRY INFORMATION**

Usage: **SITUATIONAL**

Repeat: **10**

Notes:

1. **Use this segment to identify Diagnosis codes and/or Facility Type as they relate to the information provided in the EQ segment.**
2. **Use the III segment when an information source supports or may be thought to support this level of functionality. If not supported, the information source will process without this segment.**
3. **Use this segment only one time for the Principal Diagnosis Code and only one time for Facility Type Code.**

Example: **III*BK*486~**
III*ZZ*21~

STANDARD

III Information

Level: Detail

Position: 170

Loop: 2110

Requirement: Optional

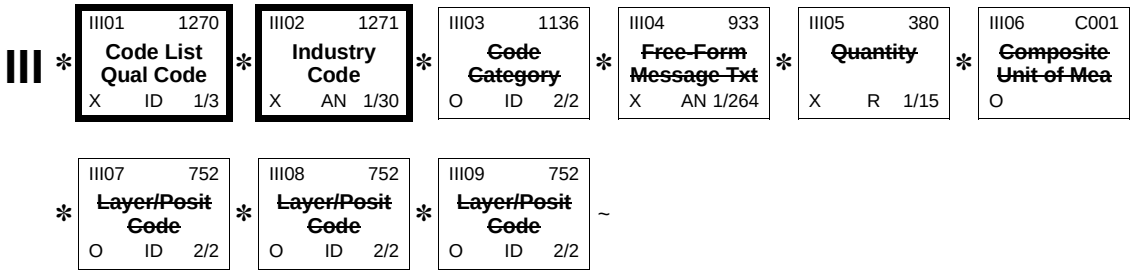
Max Use: 10

Purpose: To report information

Syntax:

1. **P0102**
   If either III01 or III02 is present, then the other is required.
2. **L030405**
   If III03 is present, then at least one of III04 or III05 are required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**III01**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list SYNTAX: P0102	**X**	**ID**	**1/3**

Use this code to specify if the code that is following in the III02 is a Principal Diagnosis Code, a Diagnosis Code or a Facility Type Code.

CODE	DEFINITION
BF	**Diagnosis**
	CODE SOURCE **131:** International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure
BK	**Principal Diagnosis**
	CODE SOURCE **131:** International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure
ZZ	**Mutually Defined** **Use this code for Facility Type Code.** **See Appendix C for Code Source 237, Place of Service from Health Care Financing Administration Claim Form.**

REQUIRED	**III02**	**1271**	**Industry Code** Code indicating a code from a specific industry code list SYNTAX: P0102 **If III01 is either BK or BF, use this element for diagnosis code from code source 131.** **If III01 is ZZ, use this element for codes identifying a place of service from code source 237. As a courtesy, the codes are listed below, however, the code list is thought to be complete at the time of publication of this implementation guideline. Since this list is subject to change, only codes contained in the document available from code source 237 are to be supported in this transaction and take precedence over any and all codes listed here.** **11 Office** **12 Home** **21 Inpatient Hospital** **22 Outpatient Hospital** **23 Emergency Room - Hospital** **24 Ambulatory Surgical Center** **25 Birthing Center** **26 Military Treatment Facility** **31 Skilled Nursing Facility** **32 Nursing Facility** **33 Custodial Care Facility** **34 Hospice** **41 Ambulance - Land** **42 Ambulance - Air or Water** **50 Federally Qualified Health Center** **51 Inpatient Psychiatric Facility** **52 Psychiatric Facility Partial Hospitalization** **53 Community Mental Health Center** **54 Intermediate Care Facility/Mentally Retarded** **55 Residential Substance Abuse Treatment Facility** **56 Psychiatric Residential Treatment Center** **60 Mass Immunization Center** **61 Comprehensive Inpatient Rehabilitation Facility** **62 Comprehensive Outpatient Rehabilitation Facility** **65 End-Stage Renal Disease Treatment Facility** **71 State or Local Public Health Clinic** **72 Rural Health Clinic** **81 Independent Laboratory** **99 Other Unlisted Facility**	**X**	**AN**	**1/30**
NOT USED	**III03**	**1136**	**Code Category**	**O**	**ID**	**2/2**
NOT USED	**III04**	**933**	**Free-Form Message Text**	**X**	**AN**	**1/264**
NOT USED	**III05**	**380**	**Quantity**	**X**	**R**	**1/15**
NOT USED	**III06**	**C001**	**COMPOSITE UNIT OF MEASURE**	**O**		
NOT USED	**III07**	**752**	**Surface/Layer/Position Code**	**O**	**ID**	**2/2**
NOT USED	**III08**	**752**	**Surface/Layer/Position Code**	**O**	**ID**	**2/2**
NOT USED	**III09**	**752**	**Surface/Layer/Position Code**	**O**	**ID**	**2/2**

IMPLEMENTATION

DEPENDENT ADDITIONAL INFORMATION

Loop: **2110D — DEPENDENT ELIGIBILITY OR BENEFIT INQUIRY INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Use this segment to identify referral or prior authorization numbers for the dependent.**
2. **Use this segment when it is necessary to provide a referral or prior authorization number for the benefit being inquired about.**

Example: **REF*9F*660415~**

STANDARD

REF Reference Identification

Level: Detail

Position: 190

Loop: 2110

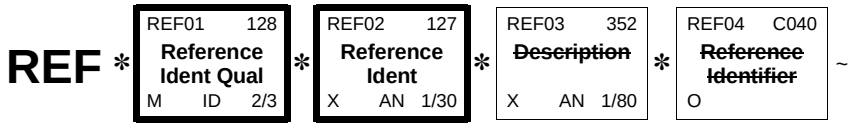
Requirement: Optional

Max Use: 1

Purpose: To specify identifying information

Syntax:
1. **R0203**
   At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

Use this code to specify or qualify the type of reference number that is following in REF02, REF03, or both.

CODE	DEFINITION
9F	**Referral Number**
G1	**Prior Authorization Number**

REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Prior Authorization or Referral Number*** SYNTAX: R0203 **Use this reference number as qualified by the preceding data element (REF01).**	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

DEPENDENT ELIGIBILITY/BENEFIT DATE

Loop: **2110D — DEPENDENT ELIGIBILITY OR BENEFIT INQUIRY INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Use this segment to convey eligibility, admission, or service dates associated with the information contained in the corresponding EQ segment.**

2. **This segment is only to be used to override dates provided in Loop 2100D when the date differs from the date provided in the DTP segment in Loop 2100D. Dates that apply to the entire request should be placed in the DTP segment in Loop 2100D.**

Example: **DTP*472*D8*19960624~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 200

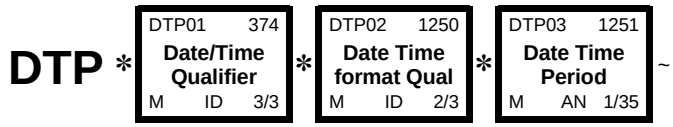
Loop: 2110

Requirement: Optional

Max Use: 9

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time	**M ID 3/3**

INDUSTRY: ***Date Time Qualifier***

CODE	DEFINITION
307	**Eligibility**
435	**Admission**
472	**Service**

REQUIRED **DTP02** **1250** **Date Time Period Format Qualifier** **M ID 2/3**
Code indicating the date format, time format, or date and time format

SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03.

Use this code to specify the format of the date(s) or time(s) that follow in the next data element.

CODE	DEFINITION
D8	**Date Expressed in Format CCYYMMDD**
RD8	**Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD**

REQUIRED **DTP03** **1251** **Date Time Period** **M AN 1/35**
Expression of a date, a time, or range of dates, times or dates and times

Use this date for the date(s) as qualified by the preceding data elements.

IMPLEMENTATION

TRANSACTION SET TRAILER

Usage: **REQUIRED**

Repeat: **1**

Notes: **1. Use this segment to mark the end of a transaction set and provide control information on the total number of segments included in the transaction set.**

Example: **SE*41*0001~**

STANDARD

SE Transaction Set Trailer

Level: Detail

Position: 210

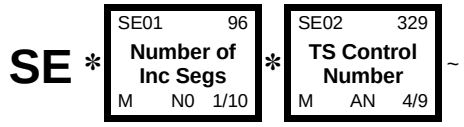
Loop: ____

Requirement: Mandatory

Max Use: 1

Purpose: To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning (ST) and ending (SE) segments)

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**SE01**	**96**	**Number of Included Segments** Total number of segments included in a transaction set including ST and SE segments *INDUSTRY:* ***Transaction Segment Count*** **Use this number to indicate the total number of segments included in the transaction set inclusive of the ST and SE segments.**	**M N0 1/10**
REQUIRED	**SE02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set **The transaction set control numbers in ST02 and SE02 must be identical. This unique number also aids in error resolution research. Start with a number, for example "0001", and increment from there. This number must be unique within a specific functional group (segments GS through GE) and interchange, but can repeat in other groups and interchanges.**	**M AN 4/9**

IMPLEMENTATION

271 Eligibility, Coverage or Benefit Information

Table 1 - Header

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
154	010	ST	Transaction Set Header	R	1	
156	020	BHT	Beginning of Hierarchical Transaction	R	1	

Table 2 - Detail, Information Source Level

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000A INFORMATION SOURCE LEVEL			>1
158	010	HL	Information Source Level	R	1	
160	025	AAA	Request Validation	S	9	
			LOOP ID - 2100A INFORMATION SOURCE NAME			1
163	030	NM1	Information Source Name	R	1	
166	040	REF	Information Source Additional Identification	S	9	
168	080	PER	Information Source Contact Information	S	3	
172	085	AAA	Request Validation	S	9	

Table 2 - Detail, Information Receiver Level

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000B INFORMATION RECEIVER LEVEL			>1
175	010	HL	Information Receiver Level	S	1	
			LOOP ID - 2100B INFORMATION RECEIVER NAME			1
178	030	NM1	Information Receiver Name	R	1	
182	040	REF	Information Receiver Additional Identification	S	9	
184	085	AAA	Information Receiver Request Validation	S	9	

Table 2 - Detail, Subscriber Level

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000C SUBSCRIBER LEVEL			>1
187	010	HL	Subscriber Level	S	1	
190	020	TRN	Subscriber Trace Number	S	3	
			LOOP ID - 2100C SUBSCRIBER NAME			1
193	030	NM1	Subscriber Name	R	1	
196	040	REF	Subscriber Additional Identification	S	9	
200	060	N3	Subscriber Address	S	1	
201	070	N4	Subscriber City/State/ZIP Code	S	1	
203	080	PER	Subscriber Contact Information	S	3	
207	085	AAA	Subscriber Request Validation	S	9	

210	100	DMG	Subscriber Demographic Information	S	1	
212	110	INS	Subscriber Relationship	S	1	
216	120	DTP	Subscriber Date	S	9	
			LOOP ID - 2110C SUBSCRIBER ELIGIBILITY OR BENEFIT INFORMATION			>1
218	130	EB	Subscriber Eligibility or Benefit Information	S	1	
233	135	HSD	Health Care Services Delivery	S	9	
238	140	REF	Subscriber Additional Identification	S	9	
240	150	DTP	Subscriber Eligibility/Benefit Date	S	20	
242	160	AAA	Subscriber Request Validation	S	9	
244	250	MSG	Message Text	S	10	
			LOOP ID - 2115C SUBSCRIBER ELIGIBILITY OR BENEFIT ADDITIONAL INFORMATION			10
246	260	III	Subscriber Eligibility or Benefit Additional Information	S	1	
249	330	LS	Loop Header	S	1	
			LOOP ID - 2120C SUBSCRIBER BENEFIT RELATED ENTITY NAME			1
250	340	NM1	Subscriber Benefit Related Entity Name	S	1	
254	360	N3	Subscriber Benefit Related Entity Address	S	1	
255	370	N4	Subscriber Benefit Related City/State/ZIP Code	S	1	
257	380	PER	Subscriber Benefit Related Entity Contact Information	S	3	
261	390	PRV	Subscriber Benefit Related Provider Information	S	1	
264	400	LE	Loop Trailer	S	1	

Table 2 - Detail, Dependent Level

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000D DEPENDENT LEVEL			>1
265	010	HL	Dependent Level	S	1	
268	020	TRN	Dependent Trace Number	S	3	
			LOOP ID - 2100D DEPENDENT NAME			1
271	030	NM1	Dependent Name	R	1	
274	040	REF	Dependent Additional Identification	S	9	
277	060	N3	Dependent Address	S	1	
278	070	N4	Dependent City/State/ZIP Code	S	1	
280	080	PER	Dependent Contact Information	S	3	
284	085	AAA	Dependent Request Validation	S	9	
287	100	DMG	Dependent Demographic Information	S	1	
289	110	INS	Dependent Relationship	S	1	
293	120	DTP	Dependent Date	S	9	
			LOOP ID - 2110D DEPENDENT ELIGIBILITY OR BENEFIT INFORMATION			>1
295	130	EB	Dependent Eligibility or Benefit Information	S	1	
309	135	HSD	Health Care Services Delivery	S	9	
314	140	REF	Dependent Additional Identification	S	9	
316	150	DTP	Dependent Eligibility/Benefit Date	S	20	
318	160	AAA	Dependent Request Validation	S	9	

320	250	MSG	Message Text	S	10	
			LOOP ID - 2115D DEPENDENT ELIGIBILITY OR BENEFIT ADDITIONAL INFORMATION			10
322	260	III	Dependent Eligibility or Benefit Additional Information	S	1	
325	330	LS	Dependent Eligibility or Benefit Information	S	1	
			LOOP ID - 2120D DEPENDENT BENEFIT RELATED ENTITY NAME			1
326	340	NM1	Dependent Benefit Related Entity Name	S	1	
330	360	N3	Dependent Benefit Related Entity Address	S	1	
331	370	N4	Dependent Benefit Related Entity City/State/ZIP Code	S	1	
333	380	PER	Dependent Benefit Related Entity Contact Information	S	3	
337	390	PRV	Dependent Benefit Related Provider Information	S	1	
340	400	LE	Loop Trailer	S	1	
341	410	SE	Transaction Set Trailer	R	1	

STANDARD

271 Eligibility, Coverage or Benefit Information

Functional Group ID: HB

This Draft Standard for Trial Use contains the format and establishes the data contents of the Eligibility, Coverage or Benefit Information Transaction Set (271) for use within the context of an Electronic Data Interchange (EDI) environment. This transaction set can be used to communicate information about or changes to eligibility, coverage or benefits from information sources (such as - insurers, sponsors, payors) to information receivers (such as - physicians, hospitals, repair facilities, third party administrators, governmental agencies). This information includes but is not limited to: benefit status, explanation of benefits, coverages, dependent coverage level, effective dates, amounts for co-insurance, co-pays, deductibles, exclusions and limitations.

Table 1 - Header

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
010	ST	Transaction Set Header	M	1	
020	BHT	Beginning of Hierarchical Transaction	M	1	

Table 2 - Detail

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
		LOOP ID - 2000			>1
010	HL	Hierarchical Level	M	1	
020	TRN	Trace	O	9	
025	AAA	Request Validation	O	9	
		LOOP ID - 2100			>1
030	NM1	Individual or Organizational Name	O	1	
040	REF	Reference Identification	O	9	
050	N2	Additional Name Information	O	1	
060	N3	Address Information	O	1	
070	N4	Geographic Location	O	1	
080	PER	Administrative Communications Contact	O	3	
085	AAA	Request Validation	O	9	
090	PRV	Provider Information	O	1	
100	DMG	Demographic Information	O	1	
110	INS	Insured Benefit	O	1	
120	DTP	Date or Time or Period	O	9	
		LOOP ID - 2110			>1
130	EB	Eligibility or Benefit Information	O	1	
135	HSD	Health Care Services Delivery	O	9	
140	REF	Reference Identification	O	9	
150	DTP	Date or Time or Period	O	20	
160	AAA	Request Validation	O	9	
170	VEH	Vehicle Information	O	1	
180	PID	Product/Item Description	O	1	
190	PDR	Property Description - Real	O	1	
200	PDP	Property Description - Personal	O	1	
210	LIN	Item Identification	O	1	

220	EM	Equipment Characteristics	O	1	
230	SD1	Safety Data	O	1	
240	PKD	Packaging Description	O	1	
250	MSG	Message Text	O	10	
		LOOP ID - 2115			>1
260	III	Information	O	1	
270	DTP	Date or Time or Period	O	5	
280	AMT	Monetary Amount	O	5	
290	PCT	Percent Amounts	O	5	
		LOOP ID - 2117			>1
300	LQ	Industry Code	O	1	
310	AMT	Monetary Amount	O	5	
320	PCT	Percent Amounts	O	5	
330	LS	Loop Header	O	1	
		LOOP ID - 2120			1
340	NM1	Individual or Organizational Name	O	1	
350	N2	Additional Name Information	O	1	
360	N3	Address Information	O	1	
370	N4	Geographic Location	O	1	
380	PER	Administrative Communications Contact	O	3	
390	PRV	Provider Information	O	1	
400	LE	Loop Trailer	O	1	
410	SE	Transaction Set Trailer	M	1	

NOTE:

2/020 If the Eligibility, Coverage or Benefit Inquiry Transaction Set (270) includes a TRN segment, then the Eligibility, Coverage or Benefit Information Transaction Set (271) must return the trace number identified in the TRN segment.

IMPLEMENTATION

TRANSACTION SET HEADER

Usage: **REQUIRED**

Repeat: **1**

Notes: **1. Use this control segment to mark the start of a transaction set. One ST segment exists for every transaction set that occurs within a functional group.**

Example: **ST*271*0001~**

STANDARD

ST Transaction Set Header

Level: Header

Position: 010

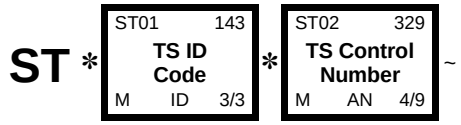
Loop: ____

Requirement: Mandatory

Max Use: 1

Purpose: To indicate the start of a transaction set and to assign a control number

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**ST01**	**143**	**Transaction Set Identifier Code** Code uniquely identifying a Transaction Set SEMANTIC: The transaction set identifier (ST01) used by the translation routines of the interchange partners to select the appropriate transaction set definition (e.g., 810 selects the Invoice Transaction Set). **Use this code to identify the transaction set ID for the transaction set that will follow the ST segment. Each X12 standard has a transaction set identifier code that is unique to that transaction set.**	**M ID 3/3**

CODE	DEFINITION
271	**Eligibility, Coverage or Benefit Information**

REQUIRED	**ST02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set	**M**	**AN**	**4/9**

The transaction set control numbers in ST02 and SE02 must be identical. This unique number also aids in error resolution research. Start with a number, for example “0001", and increment from there. This number must be unique within a specific group and interchange, but can repeat in other groups and interchanges.

IMPLEMENTATION

BEGINNING OF HIERARCHICAL TRANSACTION

Usage: **REQUIRED**

Repeat: **1**

Notes: **1. Use this required segment to start the transaction set and indicate the sequence of the hierarchical levels of information that will follow in Table 2.**

Example: **BHT*0022*11*199800114000001*19980101*1401~**

STANDARD

BHT Beginning of Hierarchical Transaction

Level: Header

Position: 020

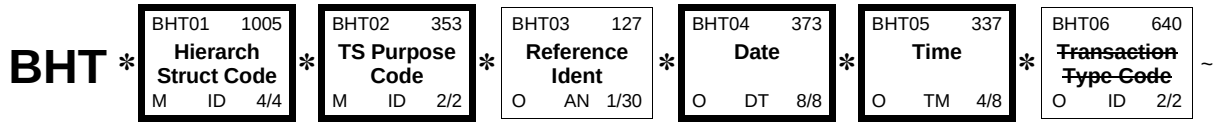
Loop: ____

Requirement: Mandatory

Max Use: 1

Purpose: To define the business hierarchical structure of the transaction set and identify the business application purpose and reference data, i.e., number, date, and time

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**BHT01**	**1005**	**Hierarchical Structure Code** Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set	**M ID 4/4**

Use this code to specify the sequence of hierarchical levels that may appear in the transaction set. This code only indicates the sequence of the levels, not the requirement that all levels be present. For example, if code "0022" is used, the dependent level may or may not be present for each subscriber.

CODE	DEFINITION
0022	**Information Source, Information Receiver, Subscriber, Dependent**

REQUIRED	**BHT02**	**353**	**Transaction Set Purpose Code** Code identifying purpose of transaction set	**M**	**ID**	**2/2**

CODE	DEFINITION
11	**Response**

SITUATIONAL	**BHT03**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**O**	**AN**	**1/30**

INDUSTRY: ***Submitter Transaction Identifier***

SEMANTIC: BHT03 is the number assigned by the originator to identify the transaction within the originator's business application system.

This element is only to be used if the transaction is processed in Real Time. This element is to be used to trace the transaction from one point to the next point, such as when the transaction is passed from one clearinghouse to another clearinghouse. This identifier is to be the identifier received in the BHT03 of the corresponding 270 transaction. This identifier is not to be passed through the complete life of the transaction, rather replaced with the identifier received in the 270. All recipients of Real Time 270 transactions are required to return the Submitter Transaction Identifier in their 271 response.

REQUIRED	**BHT04**	**373**	**Date** Date expressed as CCYYMMDD	**O**	**DT**	**8/8**

INDUSTRY: ***Transaction Set Creation Date***

SEMANTIC: BHT04 is the date the transaction was created within the business application system.

Use this date for the date the transaction set was generated.

REQUIRED	**BHT05**	**337**	**Time** Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99)	**O**	**TM**	**4/8**

INDUSTRY: ***Transaction Set Creation Time***

SEMANTIC: BHT05 is the time the transaction was created within the business application system.

Use this time for the time the transaction set was generated.

NOT USED	**BHT06**	**640**	**Transaction Type Code**	**O**	**ID**	**2/2**

IMPLEMENTATION

INFORMATION SOURCE LEVEL

Loop: **2000A — INFORMATION SOURCE LEVEL Repeat: >1**

Usage: **REQUIRED**

Repeat: **1**

Notes:

1. **Use this segment to identify the hierarchical or entity level of information being conveyed. The HL structure allows for the efficient nesting of related occurrences of information. The developers' intent is to clearly identify the relationship of the patient to the subscriber and the subscriber to the provider.**

   Additionally, multiple subscribers and/or dependents (i.e., the patient) can be grouped together under the same provider or the information for multiple providers or information receivers can be grouped together for the same payer or information source.

2. **An example of the overall structure of the transaction set when used in batch mode is:**

   Information Source Loop 2000A
   Information Receiver Loop 2000B
   Subscriber Loop 2000C
   Dependent Loop 2000D
   Eligibility or Benefit Information
   Dependent Loop 2000D
   Eligibility or Benefit Information
   Subscriber Loop 2000C
   Eligibility or Benefit Information

Example: **HL*1**20*1~**

STANDARD

HL Hierarchical Level

Level: Detail

Position: 010

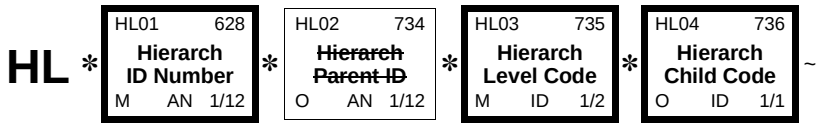
Loop: 2000 **Repeat:** >1

Requirement: Mandatory

Max Use: 1

Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure COMMENT: HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction. **Use the sequentially assigned positive number to identify each specific occurrence of an HL segment within a transaction set. It should begin with the number one and be incremented by one for each successive occurrence of the HL segment within that specific transaction set (ST through SE).** **An example of the use of the HL segment and this data element is:** **HL*1**20*1~** **NM1*PR*2*ABC INSURANCE COMPANY*****PI*842610001~**	**M AN 1/12**
NOT USED	**HL02**	**734**	**Hierarchical Parent ID Number**	**O AN 1/12**
REQUIRED	**HL03**	**735**	**Hierarchical Level Code** Code defining the characteristic of a level in a hierarchical structure COMMENT: HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information. **All data that follows an HL segment is associated with the entity identified by the level code; this association continues until the next occurrence of an HL segment.**	**M ID 1/2**

CODE	DEFINITION
20	**Information Source**

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL04**	**736**	**Hierarchical Child Code** Code indicating if there are hierarchical child data segments subordinate to the level being described COMMENT: HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment. **Use this code to indicate whether there are additional hierarchical levels subordinate to the current hierarchical level.**	**O ID 1/1**

CODE	DEFINITION
0	**No Subordinate HL Segment in This Hierarchical Structure.**
1	**Additional Subordinate HL Data Segment in This Hierarchical Structure.**

IMPLEMENTATION

REQUEST VALIDATION

Loop: **2000A — INFORMATION SOURCE LEVEL**

Usage: **SITUATIONAL**

Repeat: **9**

Notes:

1. **Use this segment when a request could not be processed at a system or application level and to indicate what action the originator of the request transaction should take.**

2. **Use of this segment at this location in the HL is to identify reasons why a request cannot be processed based on the entities identified in ISA06, ISA08, GS02 or GS03.**

Example: **AAA*Y**42*Y~**

STANDARD

AAA Request Validation

Level: Detail

Position: 025

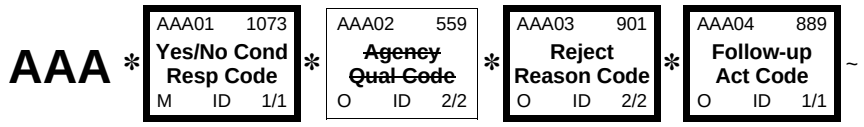
Loop: 2000

Requirement: Optional

Max Use: 9

Purpose: To specify the validity of the request and indicate follow-up action authorized

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AAA01**	**1073**	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response *INDUSTRY:* ***Valid Request Indicator*** **SEMANTIC:** AAA01 designates whether the request is valid or invalid. Code "Y" indicates that the code is valid; code "N" indicates that the code is invalid.	**M ID 1/1**

CODE	DEFINITION
N	**No** **Use this code to indicate that the request or an element in the request is not valid. The transaction has been rejected as identified by the code in AAA03.**

			Y	**Yes** **Use this code to indicate that the request is valid, however the transaction has been rejected as identified by the code in AAA03.**		
NOT USED	**AAA02**	**559**	**Agency Qualifier Code**	**O**	**ID**	**2/2**
REQUIRED	**AAA03**	**901**	**Reject Reason Code** Code assigned by issuer to identify reason for rejection	**O**	**ID**	**2/2**

Use this code to indicate the reason why the transaction was unable to be processed successfully by the entity identified in either ISA08 or GS03.

CODE	DEFINITION
04	**Authorized Quantity Exceeded** **Use this code to indicate that the transaction exceeds the number of patient requests allowed by the entity identified in either ISA08 or GS03. See section 1.3.3 Business Uses for more information regarding the number of patient requests allowed in a transaction. This is not to be used to indicate that the number of patient requests exceeds the number allowed by the Information Source identified in Loop 2100A.**
41	**Authorization/Access Restrictions** **Use this code to indicate that the entity identified in GS02 is not authorized to submit 270 transactions to the entity identified in either ISA08 or GS03. This is not to be used to indicate Authorization/Access Restrictions as related to the Information Source Identified in Loop 2100A.**
42	**Unable to Respond at Current Time** **Use this code to indicate that the entity identified in either ISA08 or GS03 is unable to process the transaction at the current time. This indicates that there is a problem within the systems of the entity identified in either ISA08 or GS03 and is not related to any problem with the Information Source Identified in Loop 2100A.**
79	**Invalid Participant Identification** **Use this code to indicate that the value in either GS02 or GS03 is invalid.**

REQUIRED	**AAA04**	**889**	**Follow-up Action Code** Code identifying follow-up actions allowed	**O**	**ID**	**1/1**

Use this code to instruct the recipient of the 271 about what action needs to be taken, if any, based on the validity code and the reject reason code (if applicable).

CODE	DEFINITION
C	**Please Correct and Resubmit**
N	**Resubmission Not Allowed**

P	**Please Resubmit Original Transaction**
R	**Resubmission Allowed**
S	**Do Not Resubmit; Inquiry Initiated to a Third Party**
Y	**Do Not Resubmit; We Will Hold Your Request and Respond Again Shortly**

IMPLEMENTATION

INFORMATION SOURCE NAME

Loop: 2100A — INFORMATION SOURCE NAME Repeat: 1

Usage: REQUIRED

Repeat: 1

Notes: 1. Use this segment to identify an entity by name and/or identification number. This NM1 loop is used to identify the eligibility or benefit information source (e.g., insurance company, HMO, IPA, employer).

Example: NM1*PR*2*ACE INSURANCE COMPANY***PI*87728~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 030

Loop: 2100 **Repeat:** >1

Requirement: Optional

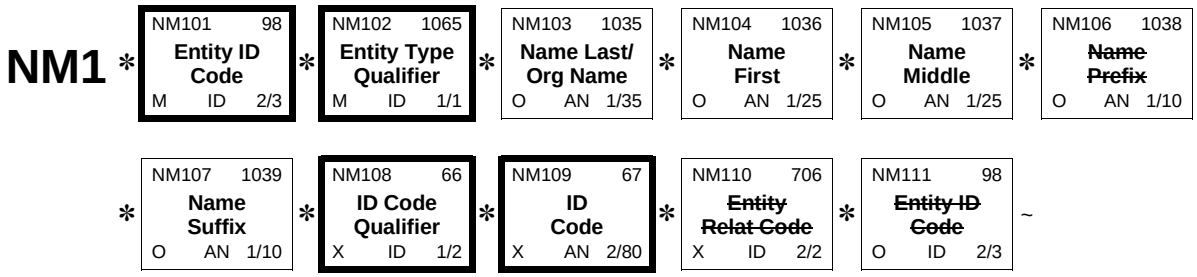
Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

Syntax: **1. P0809**
If either NM108 or NM109 is present, then the other is required.

2. C1110
If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M ID 2/3**

CODE	DEFINITION
2B	**Third-Party Administrator**
36	**Employer**

			GP	**Gateway Provider**			
			P5	**Plan Sponsor**			
			PR	**Payer**			
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103. **Use this code to indicate whether the entity is an individual person or an organization.**		**M**	**ID**	**1/1**
			CODE	**DEFINITION**			
			1	**Person**			
			2	**Non-Person Entity**			
SITUATIONAL	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name ***INDUSTRY:*** ***Information Source Last or Organization Name*** **Use this name for the organization name if NM102 is "2". Otherwise, this will be the individual's last name.** **Use if available.**		**O**	**AN**	**1/35**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name ***INDUSTRY:*** ***Information Source First Name*** **Use this name only if available and NM102 is "1".**		**O**	**AN**	**1/25**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial ***INDUSTRY:*** ***Information Source Middle Name*** **Use this name only if available and NM102 is "1".**		**O**	**AN**	**1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**		**O**	**AN**	**1/10**
SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name ***INDUSTRY:*** ***Information Source Name Suffix*** **Use name suffix only if available and NM102 is "1"; e.g., Sr., Jr., or III.**		**O**	**AN**	**1/10**

REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809	**X**	**ID**	**1/2**

Use code value "XV" if the Information Source is a Payer and the National PlanID is mandated for use. Use code value "XX" if the information source is a provider and the HCFA National Provider Identifier is mandated for use. Otherwise one of the other appropriate code values may be used.

CODE	DEFINITION
24	**Employer's Identification Number**
46	**Electronic Transmitter Identification Number (ETIN)**
FI	**Federal Taxpayer's Identification Number**
NI	**National Association of Insurance Commissioners (NAIC) Identification**
PI	**Payor Identification**
XV	**Health Care Financing Administration National PlanID** ***Required if the National PlanID is mandated for use. Otherwise, one of the other listed codes may be used.***
	CODE SOURCE **540:** Health Care Financing Administration National PlanID
XX	**Health Care Financing Administration National Provider Identifier** ***Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.***

REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Information Source Primary Identifier*** SYNTAX: P0809	**X**	**AN**	**2/80**

Use this code for the reference number as qualified by the preceding data element (NM108).

NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

INFORMATION SOURCE ADDITIONAL IDENTIFICATION

Loop: **2100A — INFORMATION SOURCE NAME**

Usage: **SITUATIONAL**

Repeat: **9**

Notes: **1. Use this segment when needed to convey other or additional identification numbers for the information source. The type of reference number is determined by the qualifier in REF01.**

Example: **REF*18*302485~**

STANDARD

REF Reference Identification

Level: Detail

Position: 040

Loop: 2100

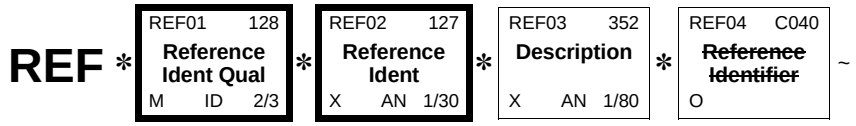
Requirement: Optional

Max Use: 9

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

Use this code to specify or qualify the type of reference number that is following in REF02, REF03, or both.

CODE	DEFINITION
18	**Plan Number**
55	**Sequence Number**

REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Information Source Additional Plan Identifier*** SYNTAX: R0203 **Use this information for the reference number as qualified by the preceding data element (REF01).**	**X**	**AN**	**1/30**
SITUATIONAL	**REF03**	**352**	**Description** A free-form description to clarify the related data elements and their content *INDUSTRY:* ***Plan Name*** SYNTAX: R0203 **Use if available.**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

INFORMATION SOURCE CONTACT INFORMATION

Loop: **2100A — INFORMATION SOURCE NAME**

Usage: **SITUATIONAL**

Repeat: **3**

Notes:

1. **This segment is recommended when the eligibility question cannot be answered electronically. It is used when the information source wishes to provide a contact for further inquiry.**

   If telephone extension is sent, it should always be in the occurrence of the communications number following the actual phone number. See the example for an illustration.

2. **If this segment is used, at a minimum either PER02 must be used or PER03 and PER04 must be used. It is recommended that at least PER02, PER03 and PER04 are sent if this segment is used.**

3. **When the communication number represents a telephone number in the United States and other countries using the North American Dialing Plan (for voice, data, fax, etc.), the communication number should always include the area code and phone number using the format AAABBBCCCC. Where AAA is the area code, BBB is the telephone number prefix, and CCCC is the telephone number (e.g. (534)224-2525 would be represented as 5342242525). The extension, when applicable, should be included in the communication number immediately after the telephone number.**

4. **By definition of the standard, if PER03 is used, PER04 is required.**

Example: **PER*IC*MEMBER SERVICES*TE*8005551654*FX*2128769304~**

Example: **PER*IC*BILLING DEPT*TE*2128763654*EX*2104*FX*2128769304~**

STANDARD

PER Administrative Communications Contact

Level: Detail

Position: 080

Loop: 2100

Requirement: Optional

Max Use: 3

Purpose: To identify a person or office to whom administrative communications should be directed

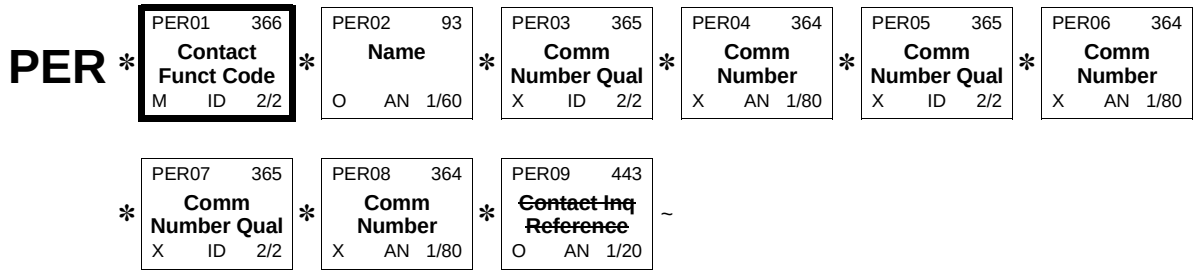
Syntax:

1. **P0304**
   If either PER03 or PER04 is present, then the other is required.

2. **P0506**
   If either PER05 or PER06 is present, then the other is required.

3. **P0708**
   If either PER07 or PER08 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PER01**	**366**	**Contact Function Code** Code identifying the major duty or responsibility of the person or group named **Use this code to specify the type of person or group to which the contact number applies.** CODE / DEFINITION **IC** — **Information Contact**	**M ID 2/2**
SITUATIONAL	**PER02**	**93**	**Name** Free-form name *INDUSTRY:* ***Information Source Contact Name*** **Use this name for the individual's name or group's name to use when contacting the individual or organization.** **Use this data element when the name of the individual to contact is not already defined or is different than the name within the prior name segment (e.g. N1 or NM1).**	**O AN 1/60**
SITUATIONAL	**PER03**	**365**	**Communication Number Qualifier** Code identifying the type of communication number SYNTAX: P0304 **Use this code to specify what type of communication number is following.** CODE / DEFINITION **ED** — **Electronic Data Interchange Access Number** **EM** — **Electronic Mail** **FX** — **Facsimile** **TE** — **Telephone**	**X ID 2/2**

SITUATIONAL	**PER04**	**364**	**Communication Number** Complete communications number including country or area code when applicable	**X**	**AN**	**1/80**

INDUSTRY: ***Information Source Communication Number***

SYNTAX: P0304

Required when PER02 is not present or when a contact number is to be sent in addition to the contact name. Use this number for the communication number as qualified by the preceding data element.

The format for US domestic phone numbers is:
AAABBBCCCC
AAA = Area Code
BBBCCCC = Local Number

SITUATIONAL	**PER05**	**365**	**Communication Number Qualifier** Code identifying the type of communication number	**X**	**ID**	**2/2**

SYNTAX: P0506

Use this code to specify what type of communication number is following.

CODE	DEFINITION
ED	**Electronic Data Interchange Access Number**
EM	**Electronic Mail**
EX	**Telephone Extension**
FX	**Facsimile**
TE	**Telephone**

SITUATIONAL	**PER06**	**364**	**Communication Number** Complete communications number including country or area code when applicable	**X**	**AN**	**1/80**

INDUSTRY: ***Information Source Communication Number***

SYNTAX: P0506

Required when an additional contact number is to be sent. Use this number for the communication number as qualified by the preceding data element.

The format for US domestic phone numbers is:
AAABBBCCCC
AAA = Area Code
BBBCCCC = Local Number

SITUATIONAL	**PER07**	**365**	**Communication Number Qualifier** Code identifying the type of communication number	**X**	**ID**	**2/2**

SYNTAX: P0708

Use this code to specify what type of communication number is following.

CODE	DEFINITION
ED	**Electronic Data Interchange Access Number**
EM	**Electronic Mail**

			EX **Telephone Extension**			
			FX **Facsimile**			
			TE **Telephone**			
SITUATIONAL	**PER08**	**364**	**Communication Number** Complete communications number including country or area code when applicable *INDUSTRY:* ***Information Source Communication Number*** SYNTAX: P0708 **Required when an additional contact number is to be sent. Use this number for the communication number as qualified by the preceding data element.** **The format for US domestic phone numbers is:** **AAABBBCCCC** **AAA = Area Code** **BBBCCCC = Local Number**	**X**	**AN**	**1/80**
NOT USED	**PER09**	**443**	**Contact Inquiry Reference**	**O**	**AN**	**1/20**

IMPLEMENTATION

REQUEST VALIDATION

Loop: **2100A — INFORMATION SOURCE NAME**

Usage: **SITUATIONAL**

Repeat: **9**

Notes:

1. **Use this segment when a request could not be processed at a system or application level and to indicate what action the originator of the request transaction should take.**

2. **Use this segment to indicate problems in processing the transaction specifically related to the information source data contained in the original 270 transaction's information source name loop (Loop 2100A) or to indicate that the information source itself is experiencing system problems.**

Example: **AAA*Y**42*Y~**

STANDARD

AAA Request Validation

Level: Detail

Position: 085

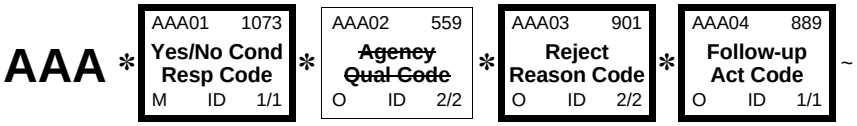
Loop: 2100

Requirement: Optional

Max Use: 9

Purpose: To specify the validity of the request and indicate follow-up action authorized

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	AAA01	1073	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response	M	ID	1/1

INDUSTRY: ***Valid Request Indicator***

SEMANTIC: AAA01 designates whether the request is valid or invalid. Code "Y" indicates that the code is valid; code "N" indicates that the code is invalid.

CODE	DEFINITION
N	**No** **Use this code to indicate that the request or an element in the request is not valid. The transaction has been rejected as identified by the code in AAA03.**
Y	**Yes** **Use this code to indicate that the request is valid, however the transaction has been rejected as identified by the code in AAA03.**

NOT USED	AAA02	559	**Agency Qualifier Code**	O	ID	2/2
REQUIRED	AAA03	901	**Reject Reason Code** Code assigned by issuer to identify reason for rejection	O	ID	2/2

Use this code for the reason why the transaction was unable to be processed successfully. This may indicate problems with the system, the application, or the data content.

CODE	DEFINITION
04	**Authorized Quantity Exceeded** **Use this code to indicate that the transaction exceeds the number of patient requests allowed by the Information Source identified in Loop 2100A. See section 1.3.3 Business Uses for more information regarding the number of patient requests allowed in a transaction.**
41	**Authorization/Access Restrictions** **Use this code to indicate that the entity identified in ISA06 or GS02 is not authorized to submit 270 transactions to the Information Source Identified in Loop 2100A.**
42	**Unable to Respond at Current Time** **Use this code to indicate that Information Source Identified in Loop 2100A is unable to process the transaction at the current time. This indicates that there is a problem within the Information Source's system.**

			79	**Invalid Participant Identification** **Use this code to indicate that Information Source Identified in Loop 2100A is invalid. If the transaction is processed by a clearing house, VAN, etc., use this code to indicate that the Information Source Identified in Loop 2100A is not a valid identifier for Information Sources the clearing house, VAN, etc. have access to. If the transaction is sent directly to the Information Source, use this code to indicate that the Information Source Identified in Loop 2100A is not a valid identifier.**			
			80	**No Response received - Transaction Terminated** **Use this code only if the transaction is processed by a clearing house, VAN, etc. Use this code to indicate that the transaction was sent to the Information Source Identified in Loop 2100A however no response was received in the expected time frame.**			
			T4	**Payer Name or Identifier Missing** **Use this code to indicate that either the name or identifier for Information Source Identified in Loop 2100A is missing.**			
REQUIRED	**AAA04**	**889**	**Follow-up Action Code** Code identifying follow-up actions allowed		**O**	**ID**	**1/1**

Use this code to instruct the recipient of the 271 about what action needs to be taken, if any, based on the validity code and the reject reason code (if applicable).

CODE	DEFINITION
C	**Please Correct and Resubmit**
N	**Resubmission Not Allowed**
P	**Please Resubmit Original Transaction**
R	**Resubmission Allowed**
S	**Do Not Resubmit; Inquiry Initiated to a Third Party**
W	**Please Wait 30 Days and Resubmit**
X	**Please Wait 10 Days and Resubmit**
Y	**Do Not Resubmit; We Will Hold Your Request and Respond Again Shortly**

IMPLEMENTATION

INFORMATION RECEIVER LEVEL

Loop: **2000B — INFORMATION RECEIVER LEVEL** **Repeat:** **>1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Use this segment to identify the hierarchical or entity level of information being conveyed. The HL structure allows for the efficient nesting of related occurrences of information. The developers' intent is to clearly identify the relationship of the patient to the subscriber and the subscriber to the provider.**

   Additionally, multiple subscribers and/or dependents (i.e., the patient) can be grouped together under the same provider or the information for multiple providers or information receivers can be grouped together for the same payer or information source.

2. **An example of the overall structure of the transaction set when used in batch mode is:**

   Information Source Loop 2000A
   Information Receiver Loop 2000B
   Subscriber Loop 2000C
   Dependent Loop 2000D
   Eligibility or Benefit Information
   Dependent Loop 2000D
   Eligibility or Benefit Information
   Subscriber Loop 2000C
   Eligibility or Benefit Information

3. **This segment is required if this loop is used.**

Example: **HL*2*1*21*1~**

STANDARD

HL Hierarchical Level

Level: Detail

Position: 010

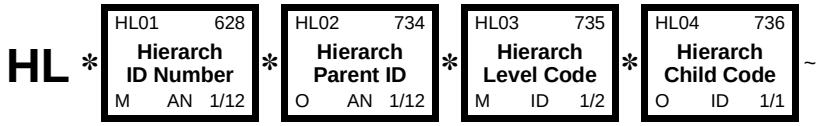
Loop: 2000 **Repeat:** >1

Requirement: Mandatory

Max Use: 1

Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure COMMENT: HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction. **Use the sequentially assigned positive number to identify each specific occurrence of an HL segment within a transaction set. It should begin with the number one and be incremented by one for each successive occurrence of the HL segment within that specific transaction set (ST through SE).** **An example of the use of the HL segment and this data element is:** **HL*1**20*1~** **NM1*PR*2*ABC INSURANCE COMPANY*****PI*842610001~** **HL*2*1*21*1~** **NM1*1P*1*JONES*MARCUS***MD*SV*0202034~**	**M AN 1/12**
REQUIRED	**HL02**	**734**	**Hierarchical Parent ID Number** Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to COMMENT: HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate. **Use this ID number to identify the specific hierarchical level to which this level is subordinate.**	**O AN 1/12**
REQUIRED	**HL03**	**735**	**Hierarchical Level Code** Code defining the characteristic of a level in a hierarchical structure COMMENT: HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information. **All data that follows an HL segment is associated with the entity identified by the level code; this association continues until the next occurrence of an HL segment.**	**M ID 1/2**

CODE	DEFINITION
21	**Information Receiver**

REQUIRED **HL04** **736** **Hierarchical Child Code** **O ID 1/1**

Code indicating if there are hierarchical child data segments subordinate to the level being described

COMMENT: HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

Use this code to indicate whether there are additional hierarchical levels subordinate to the current hierarchical level.

CODE	DEFINITION
0	**No Subordinate HL Segment in This Hierarchical Structure.**
1	**Additional Subordinate HL Data Segment in This Hierarchical Structure.**

IMPLEMENTATION

INFORMATION RECEIVER NAME

Loop: **2100B — INFORMATION RECEIVER NAME** **Repeat:** **1**

Usage: **REQUIRED**

Repeat: **1**

Notes: **1. Use this segment to identify an entity by name and/or identification number. This NM1 loop is used to identify the eligibility/benefit information receiver (e.g., provider, medical group, IPA, or hospital).**

Example: **NM1*1P*1*JONES*MARCUS***MD*34*111223333~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 030

Loop: 2100 **Repeat:** >1

Requirement: Optional

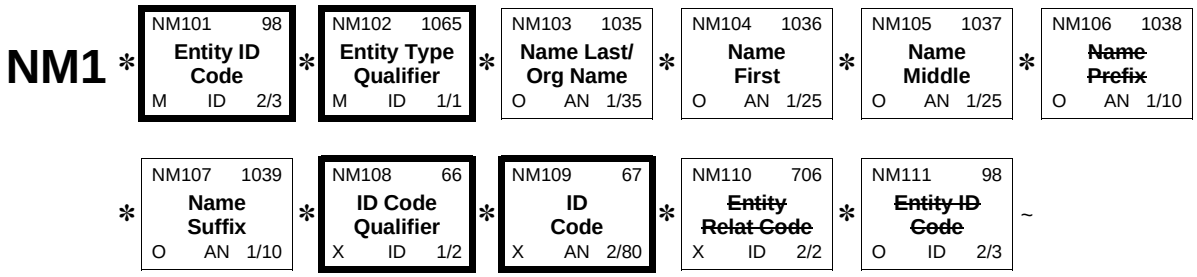
Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

Syntax: **1. P0809**
If either NM108 or NM109 is present, then the other is required.

2. C1110
If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M ID 2/3**

CODE	DEFINITION
1P	**Provider**
2B	**Third-Party Administrator**

			36 **Employer**			
			80 **Hospital**			
			FA **Facility**			
			GP **Gateway Provider**			
			P5 **Plan Sponsor**			
			PR **Payer**			
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. **Use this code to indicate whether the entity is an individual person or an organization.** CODE / DEFINITION **1** **Person** **2** **Non-Person Entity**	**M**	**ID**	**1/1**
SITUATIONAL	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name INDUSTRY: ***Information Receiver Last or Organization Name*** **Use this name for the organization name if the entity type qualifier is a non-person entity. Otherwise, this will be the individual's last name.** **Use if available.**	**O**	**AN**	**1/35**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name INDUSTRY: ***Information Receiver First Name*** **Use this name only if available and NM102 is "1".**	**O**	**AN**	**1/25**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial INDUSTRY: ***Information Receiver Middle Name*** **Use this name only if available and NM102 is "1".**	**O**	**AN**	**1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**AN**	**1/10**
SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name INDUSTRY: ***Information Receiver Name Suffix*** **Use name suffix only if available and NM102 is "1"; e.g., Sr., Jr., or III.**	**O**	**AN**	**1/10**

REQUIRED **NM108** **66** **Identification Code Qualifier** **X ID 1/2**

Code designating the system/method of code structure used for Identification Code (67)

SYNTAX: P0809

Use this element to qualify the identification number submitted in NM109. This is the number that the information source associates with the information receiver. Because only one number can be submitted in NM109, the following hierarchy must be used. Additional identifiers are to be placed in the REF segment. If the information receiver is a provider and the National Provider ID is mandated for use, code value "XX" must be used. Otherwise, one of the following codes may be used with the following hierarchy applied: Use the first code that applies: "SV", "PP", "FI", "34". The code "SV" is recommended to be used prior to the mandated use of the National Provider ID. If the information receiver is a payer and the HCFA National PlanID is mandated for use, code value "XV" must be used, otherwise, use code value "PI". If the information receiver is an employer, use code value "24".

CODE	DEFINITION
24	**Employer's Identification Number** **Use this code only when the 270/271 transaction sets are used by an employer inquiring about eligibility and benefits of their employees.**
34	**Social Security Number** **The social security number may not be used for any Federally administered programs such as Medicare.**
FI	**Federal Taxpayer's Identification Number**
PI	**Payor Identification** **Use this code only when the information receiver is a payer.**
PP	**Pharmacy Processor Number**
SV	**Service Provider Number** **Use this code for the identification number assigned by the information source.**
XV	**Health Care Financing Administration National PlanID** ***Required if the National PlanID is mandated for use. Otherwise, one of the other listed codes may be used.***
	CODE SOURCE **540:** Health Care Financing Administration National PlanID
XX	**Health Care Financing Administration National Provider Identifier** ***Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.*** **See code source 537.**

REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Information Receiver Identification Number*** SYNTAX: P0809 **Use this code for the reference number as qualified by the preceding data element (NM108).**	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

INFORMATION RECEIVER ADDITIONAL IDENTIFICATION

Loop: **2100B — INFORMATION RECEIVER NAME**

Usage: **SITUATIONAL**

Repeat: **9**

Notes: **1. Use this segment when needed to convey other or additional identification numbers for the information receiver. The type of reference number is determined by the qualifier in REF01.**

Example: **REF*EO*477563928~**

STANDARD

REF Reference Identification

Level: Detail

Position: 040

Loop: 2100

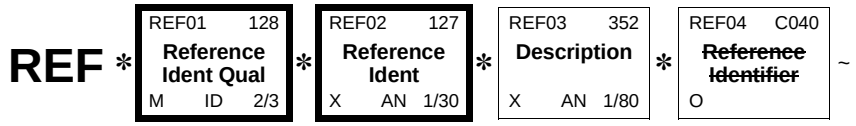
Requirement: Optional

Max Use: 9

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

Use this code to specify or qualify the type of reference number that is following in REF02, REF03, or both.

CODE	DEFINITION
0B	**State License Number** **The state assigning the license number must be identified in REF03.**
1C	**Medicare Provider Number**
1D	**Medicaid Provider Number**

			1J	**Facility ID Number**			
			4A	**Personal Identification Number (PIN)**			
			CT	**Contract Number**			
			EL	**Electronic device pin number**			
			EO	**Submitter Identification Number**			
			HPI	**Health Care Financing Administration National Provider Identifier** **The Health Care Financing Administration National Provider Identifier may be used in this segment prior to being mandated for use.**			
				CODE SOURCE **537:** Health Care Financing Administration National Provider Identifier			
			JD	**User Identification**			
			N5	**Provider Plan Network Identification Number**			
			N7	**Facility Network Identification Number**			
			Q4	**Prior Identifier Number**			
			SY	**Social Security Number** **The social security number may not be used for any Federally administered programs such as Medicare.**			
			TJ	**Federal Taxpayer's Identification Number**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Information Receiver Additional Identifier*** SYNTAX: R0203 **Use this information for the reference number as qualified by the preceding data element (REF01).**		**X**	**AN**	**1/30**
SITUATIONAL	**REF03**	**352**	**Description** A free-form description to clarify the related data elements and their content *INDUSTRY:* ***License Number State Code*** SYNTAX: R0203 **Use this element for the two character state code of the state assigning the identifier supplied in REF02. This element is required if the identifier supplied in REF02 is the State License Number. See Code source 22: States and Outlying Areas of the U.S.**		**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**		**O**		

IMPLEMENTATION

INFORMATION RECEIVER REQUEST VALIDATION

Loop: **2100B — INFORMATION RECEIVER NAME**

Usage: **SITUATIONAL**

Repeat: **9**

Notes:

1. **Use this segment when a request could not be processed at a system or application level and to indicate what action the originator of the request transaction should take.**

2. **Use this segment to indicate problems in processing the transaction specifically related to the information receiver data contained in the original 270 transaction's information receiver name loop (Loop 2100B).**

Example: **AAA*N**43*C~**

STANDARD

AAA Request Validation

Level: Detail

Position: 085

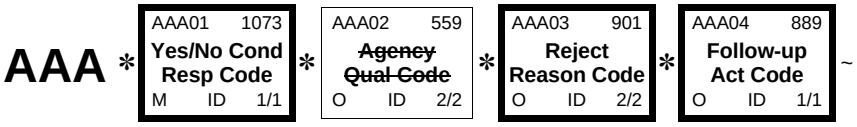
Loop: 2100

Requirement: Optional

Max Use: 9

Purpose: To specify the validity of the request and indicate follow-up action authorized

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	AAA01	1073	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response *INDUSTRY:* ***Valid Request Indicator*** **SEMANTIC:** AAA01 designates whether the request is valid or invalid. Code "Y" indicates that the code is valid; code "N" indicates that the code is invalid.	M ID 1/1
			N — **No** **Use this code to indicate that the request or an element in the request is not valid. The transaction has been rejected as identified by the code in AAA03.**	
			Y — **Yes** **Use this code to indicate that the request is valid, however the transaction has been rejected as identified by the code in AAA03.**	
NOT USED	AAA02	559	**Agency Qualifier Code**	O ID 2/2
REQUIRED	AAA03	901	**Reject Reason Code** Code assigned by issuer to identify reason for rejection	O ID 2/2
			Use this code for the reason why the transaction was unable to be processed successfully. This may indicate problems with the system, the application, or the data content.	
			15 — **Required application data missing** **Use this code only when the information receiver's additional identification is missing.**	
			41 — **Authorization/Access Restrictions**	
			43 — **Invalid/Missing Provider Identification**	
			44 — **Invalid/Missing Provider Name**	
			45 — **Invalid/Missing Provider Specialty**	
			46 — **Invalid/Missing Provider Phone Number**	
			47 — **Invalid/Missing Provider State**	
			48 — **Invalid/Missing Referring Provider Identification Number**	
			50 — **Provider Ineligible for Inquiries**	
			51 — **Provider Not on File**	
			79 — **Invalid Participant Identification** **Use this code only when the information receiver is not a provider or payer.**	

			97	**Invalid or Missing Provider Address**			
			T4	**Payer Name or Identifier Missing** **Use this code only when the information receiver is a payer.**			
REQUIRED	**AAA04**	**889**	**Follow-up Action Code** Code identifying follow-up actions allowed		**O**	**ID**	**1/1**

Use this code to instruct the recipient of the 271 about what action needs to be taken, if any, based on the validity code and the reject reason code (if applicable).

CODE	DEFINITION
C	**Please Correct and Resubmit**
N	**Resubmission Not Allowed**
R	**Resubmission Allowed**
S	**Do Not Resubmit; Inquiry Initiated to a Third Party**
W	**Please Wait 30 Days and Resubmit**
X	**Please Wait 10 Days and Resubmit**
Y	**Do Not Resubmit; We Will Hold Your Request and Respond Again Shortly**

IMPLEMENTATION

SUBSCRIBER LEVEL

Loop: **2000C — SUBSCRIBER LEVEL Repeat: >1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Use this segment to identify the hierarchical or entity level of information being conveyed. The HL structure allows for the efficient nesting of related occurrences of information. The developers' intent is to clearly identify the relationship of the patient to the subscriber and the subscriber to the provider.**

   Additionally, multiple subscribers and/or dependents (i.e., the patient) can be grouped together under the same provider or the information for multiple providers or information receivers can be grouped together for the same payer or information source.

2. **An example of the overall structure of the transaction set when used in batch mode is:**

   Information Source Loop 2000A
   Information Receiver Loop 2000B
   Subscriber Loop 2000C
   Dependent Loop 2000D
   Eligibility or Benefit Information
   Dependent Loop 2000D
   Eligibility or Benefit Information
   Subscriber Loop 2000C
   Eligibility or Benefit Information

3. **This segment is required if this loop is used.**

Example: **HL*3*2*22*1~**

STANDARD

HL Hierarchical Level

Level: Detail

Position: 010

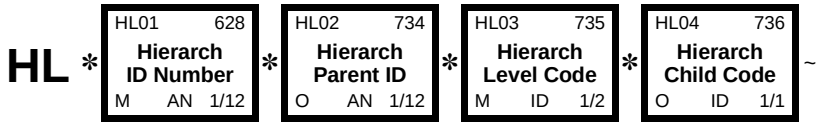
Loop: 2000 **Repeat:** >1

Requirement: Mandatory

Max Use: 1

Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure COMMENT: HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction. **An example of the use of the HL segment and this data element is:** **HL*1**20*1~** **NM1*PR*2*ABC INSURANCE COMPANY*****PI*842610001~** **HL*2*1*21*1~** **NM1*1P*1*JONES*MARCUS***MD*SV*0202034~** **HL*3*2*22*1~** **NM1*IL*1*SMITH*ROBERT*B***MI*11122333301~** **HL*4*3*23*0~** **NM1*03*1*SMITH*MARY*LOU~** **Eligibility/Benefit Data** **HL*5*2*22*0~** **NM1*IL*1*BROWN*JOHN*E***MI*22211333301~** **Eligibility/Benefit Data** **Use the sequentially assigned positive number to identify each specific occurrence of an HL segment within a transaction set. It should begin with the number one and be incremented by one for each successive occurrence of the HL segment within that specific transaction set (ST through SE).**	**M AN 1/12**
REQUIRED	**HL02**	**734**	**Hierarchical Parent ID Number** Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to COMMENT: HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate. **Use this ID number to identify the specific hierarchical level to which this level is subordinate.**	**O AN 1/12**

REQUIRED **HL03** **735** **Hierarchical Level Code** **M ID 1/2**
Code defining the characteristic of a level in a hierarchical structure

COMMENT: HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information.

All data that follows an HL segment is associated with the entity identified by the level code; this association continues until the next occurrence of an HL segment.

CODE	DEFINITION
22	**Subscriber** **Use the subscriber level to identify the insured or subscriber of the health care coverage. This entity may or may not be the actual patient.**

REQUIRED **HL04** **736** **Hierarchical Child Code** **O ID 1/1**
Code indicating if there are hierarchical child data segments subordinate to the level being described

COMMENT: HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

Use this code to indicate whether there are additional hierarchical levels subordinate to the current hierarchical level.

Because of the hierarchical structure, the code value in the HL04 at the Loop 2000C level should be “1" if a Loop 2000D level (dependent) is associated with this subscriber. If no Loop 2000D level exists for this subscriber, then the code value for HL04 should be ”0" (zero).

CODE	DEFINITION
0	**No Subordinate HL Segment in This Hierarchical Structure.**
1	**Additional Subordinate HL Data Segment in This Hierarchical Structure.**

IMPLEMENTATION

SUBSCRIBER TRACE NUMBER

Loop: 2000C — SUBSCRIBER LEVEL

Usage: SITUATIONAL

Repeat: 3

Notes:

1. Use this segment to convey a unique trace or reference number. See Section 1.3.6 Information Linkage for additional information.

2. An information source may receive up to two TRN segments in each loop 2000C of a 270 transaction and must return each of them in loop 2000C of the 271 transaction with a value of “2" in TRN01.

3. If the subscriber is the patient, an information source may add one TRN segment to loop 2000C with a value of “1" in TRN01 and must identify themselves in TRN03.

4. If this transaction passes through a clearinghouse, the clearinghouse will receive from the information source the information receiver’s TRN segment and the clearinghouse’s TRN segment with a value of “2" in TRN01. Since the ultimate destination of the transaction is the information receiver, if the clearinghouse intends on passing their TRN segment to the information receiver, the clearinghouse must change the value in TRN01 to ”1" of their TRN segment. This must be done since the trace number in the clearinghouse’s TRN segment is not actually a referenced transaction trace number to the information receiver.

Example:
TRN*2*98175-012547*9877281234*RADIOLOGY~
TRN*2*109834652831*9XYZCLEARH*REALTIME~
TRN*1*209991094361*9ABCINSURE~

The above example represents how an information source would respond. The first TRN segment was initiated by the information receiver. The second TRN segment was initiated by the clearinghouse. The third TRN segment was initiated by the information source.

Example:
TRN*2*98175-012547*9877281234*RADIOLOGY~
TRN*1*109834652831*9XYZCLEARH*REALTIME~
TRN*1*209991094361*9ABCINSURE~

The above example represents how a clearinghouse would respond to the same set of TRN segments if the clearinghouse intends to pass their TRN segment on to the information receiver. If the clearinghouse does not intend to pass their TRN segment on to the information receiver, only the first and third TRN segments in the example would be sent.

STANDARD

TRN Trace

Level: Detail

Position: 020

Loop: 2000

Requirement: Optional

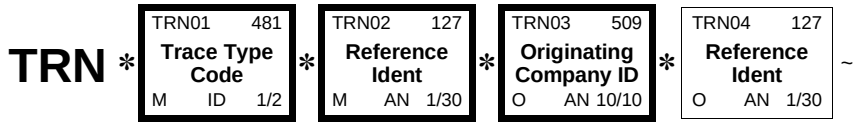
Max Use: 9

Purpose: To uniquely identify a transaction to an application

Set Notes:

1. If the Eligibility, Coverage or Benefit Inquiry Transaction Set (270) includes a TRN segment, then the Eligibility, Coverage or Benefit Information Transaction Set (271) must return the trace number identified in the TRN segment.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**TRN01**	**481**	**Trace Type Code** Code identifying which transaction is being referenced	**M ID 1/2**

CODE	DEFINITION
1	**Current Transaction Trace Numbers** **The term "Current Transaction Trace Numbers" refers to trace or reference numbers assigned by the creator of the 271 transaction (the information source).** **If a clearinghouse has assigned a TRN segment and intends on returning their TRN segment in the 271 response to the information receiver, they must convert the value in TRN01 to "1" (since it will be returned by the information source as a "2").**
2	**Referenced Transaction Trace Numbers** **The term "Referenced Transaction Trace Numbers" refers to trace or reference numbers originally sent in the 270 transaction and now returned in the 271.**

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**TRN02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Trace Number*** SEMANTIC: TRN02 provides unique identification for the transaction.	**M AN 1/30**

REQUIRED	**TRN03**	**509**	**Originating Company Identifier**	**O**	**AN**	**10/10**

A unique identifier designating the company initiating the funds transfer instructions. The first character is one-digit ANSI identification code designation (ICD) followed by the nine-digit identification number which may be an IRS employer identification number (EIN), data universal numbering system (DUNS), or a user assigned number; the ICD for an EIN is 1, DUNS is 3, user assigned number is 9

INDUSTRY: ***Trace Assigning Entity Identifier***

SEMANTIC: TRN03 identifies an organization.

If TRN01 is "2", this is the value received in the original 270 transaction.

If TRN01 is "1", use this information to identify the organization that assigned this trace number.

The first position must be either a "1" if an EIN is used, a "3" if a DUNS is used or a "9" if a user assigned identifier is used.

SITUATIONAL	**TRN04**	**127**	**Reference Identification**	**O**	**AN**	**1/30**

Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

INDUSTRY: ***Trace Assigning Entity Additional Identifier***

SEMANTIC: TRN04 identifies a further subdivision within the organization.

If TRN01 is "2", this is the value received in the original 270 transaction.

If TRN01 is "1", use this information if necessary to further identify a specific component, such as a specific division or group of the entity identified in the previous data element (TRN03).

IMPLEMENTATION

SUBSCRIBER NAME

Loop: **2100C — SUBSCRIBER NAME** **Repeat:** **1**

Usage: **REQUIRED**

Repeat: **1**

Notes:
1. **Use this segment to identify an entity by name and/or identification number. This NM1 loop is used to identify the insured or subscriber.**

Example: **NM1*IL*1*SMITH*JOHN*L***MI*44411555501~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 030

Loop: 2100 **Repeat:** >1

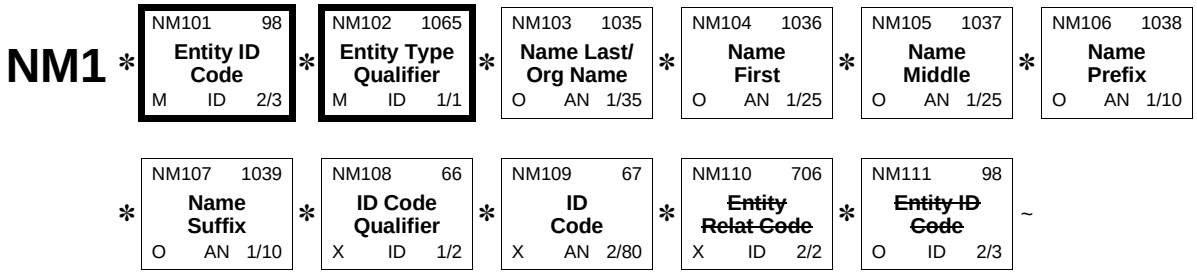
Requirement: Optional

Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

Syntax:
1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M ID 2/3**

CODE	DEFINITION
IL	**Insured or Subscriber**

REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity	**M**	**ID**	**1/1**

SEMANTIC: NM102 qualifies NM103.

CODE	DEFINITION
1	**Person**

SITUATIONAL	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name	**O**	**AN**	**1/35**

INDUSTRY: ***Subscriber Last Name***

Use this name for the subscriber's last name.

Required unless a rejection response is generated and this element was not valued in the request.

SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name	**O**	**AN**	**1/25**

INDUSTRY: ***Subscriber First Name***

Use this name for the subscriber's first name.

Required unless a rejection response is generated and this element was not valued in the request.

SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial	**O**	**AN**	**1/25**

INDUSTRY: ***Subscriber Middle Name***

Use this name for the subscriber's middle name or initial.

Change second note: Required if this is availalble from the Information Source's database unless a rejection response is generated and this element was not valued in the request.

SITUATIONAL	**NM106**	**1038**	**Name Prefix** Prefix to individual name	**O**	**AN**	**1/10**

INDUSTRY: ***Subscriber Name Prefix***

Use this only to convey a persons Military Rank.

See Appendix C for Code Source DOD1, Military Health Systems Functional Area Manual - Data.

SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name	**O**	**AN**	**1/10**

INDUSTRY: ***Subscriber Name Suffix***

Use this for the suffix to an individual's name; e.g., Sr., Jr., or III.

Use if available.

SITUATIONAL	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67)	**X**	**ID**	**1/2**

SYNTAX: P0809

Use this element to qualify the identification number submitted in NM109. This is the primary number that the information source associates with the subscriber.

Required unless a rejection response is generated and this element was not valued in the request.

CODE	DEFINITION
MI	**Member Identification Number** **This code may only be used prior to the mandated use of code "ZZ". This is the unique number the payer or information source uses to identify the insured (e.g., Health Insurance Claim Number, Medicaid Recipient ID Number, HMO Member ID, etc.).**
ZZ	**Mutually Defined** **The value 'ZZ', when used in this data element shall be defined as "HIPAA Individual Identifier" once this identifier has been adopted. Under the Health Insurance Portability and Accountability Act of 1996, the Secretary of the Department of Health and Human Services must adopt a standard individual identifier for use in this transaction.**

SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code	**X**	**AN**	**2/80**

INDUSTRY: ***Subscriber Primary Identifier***

SYNTAX: P0809

Use this code for the reference number as qualified by the preceding data element (NM108).

Required unless a rejection response is generated and this element was not valued in the request.

NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

SUBSCRIBER ADDITIONAL IDENTIFICATION

Loop: **2100C — SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **9**

Notes:

1. **Use this segment to supply an identification number other than or in addition to the Member Identification Number. The type of reference number is determined by the qualifier in REF01.**

2. **Required if the Information Source requires additional identifiers necessary to identify the Subscriber for other transactions such as claims, authorizations, etc.**

3. **Health Insurance Claim (HIC) Number or Medicaid Recipient Identification Numbers are to be provided in the NM1 segment as a Member Identification Number when it is the primary number an information source knows a member by (such as for Medicare or Medicaid). Do not use this segment for the Health Insurance Claim (HIC) Number or Medicaid Recipient Identification Number unless they are different from the Member Identification Number provided in the NM1 segment.**

4. **If the 270 request contained a REF segment with a Patient Account Number in Loop 2100C/REF02 with REF01 equal EJ, then it must be returned in the 271 transaction using this segment.**

Example: **REF*18*660415~**

STANDARD

REF Reference Identification

Level: Detail

Position: 040

Loop: 2100

Requirement: Optional

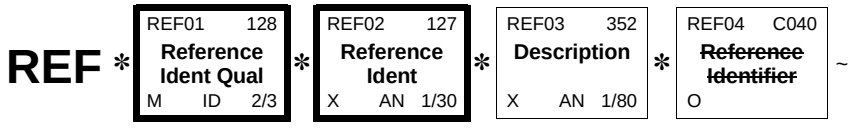
Max Use: 9

Purpose: To specify identifying information

Syntax:

1. **R0203**
   At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	**Reference Identification Qualifier** Code qualifying the Reference Identification	M ID 2/3

Use this code to specify or qualify the type of reference number that is following in REF02, REF03, or both.

CODE	DEFINITION
18	Plan Number
1L	Group or Policy Number Use this code only if it cannot be determined if the number is a Group Number or a Policy number. Use codes IG or 6P when they can be determined.
1W	Member Identification Number Use only if Loop 2100C NM108 contains ZZ, and is prior to the mandated use of the HIPAA Unique Patient Identifier.
3H	Case Number
49	Family Unit Number This is the Suffix to the Subscriber's Member Identification Number, which allows the information source to use one identification number as the base number for each family member. The suffix identifies the individual family member. Only the suffix is to be entered here. The Member Identification Number is to be entered in Loop 2100C NM109 or REF02. If the complete Member Identification Number with the suffix is entered in Loop 2100C NM109 or REF02, the suffix should not be entered here.
6P	Group Number
A6	Employee Identification Number
EA	Medical Record Identification Number
EJ	Patient Account Number
F6	Health Insurance Claim (HIC) Number See segment note 3.

GH	**Identification Card Serial Number** **Use this code when the Identification Card has a number in addition to the Member Identification Number or Identity Card Number. The Identification Card Serial Number uniquely identifies the card when multiple cards have been or will be issued to a member (e.g., on a monthly basis, replacement cards). This is particularly prevalent in the Medicaid environment.**
HJ	**Identity Card Number** **Use this code when the Identity Card Number is different than the Member Identification Number. This is particularly prevalent in the Medicaid environment.**
IF	**Issue Number**
IG	**Insurance Policy Number**
ML	**Military Rank/Civilian Pay Grade Number** **If conveying a Military rank see Code Source DOD1: Military Heatlh Systems Functional Area Manual - Data.** **If conveying a Civilian Pay Grade Number see Code Source DOD2: Department of Defense Instruction (DODI) 1000.13.**
N6	**Plan Network Identification Number**
NQ	**Medicaid Recipient Identification Number** **See segment note 2.**
Q4	**Prior Identifier Number** **This code is to be used when a corrected or new identification number is returned in NM109, the originally submitted identification number is to be returned in REF02. To be used in conjunction with code “001" in INS03 and code ”25" in INS04.**
SY	**Social Security Number** **The social security number may not be used for any Federally administered programs such as Medicare.**

REQUIRED **REF02** **127** **Reference Identification** **X AN 1/30**

Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

INDUSTRY: ***Subscriber Supplemental Identifier***

SYNTAX: R0203

Use this information for the reference number as qualified by the preceding data element (REF01).

SITUATIONAL	**REF03**	**352**	**Description** A free-form description to clarify the related data elements and their content *INDUSTRY:* ***Plan Sponsor Name*** **SYNTAX:** R0203 **Use if available.**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

SUBSCRIBER ADDRESS

Loop: **2100C — SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Use this segment to identify address information for a subscriber.**
2. **Use of this segment is required if the transaction is not rejected and address information is available from the information source's database.**
3. **Do not return address information from the 270 request.**

Example: **N3*15197 BROADWAY AVENUE*APT 215~**

STANDARD

N3 Address Information

Level: Detail

Position: 060

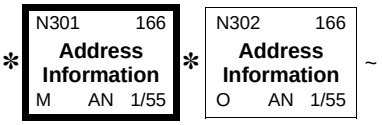
Loop: 2100

Requirement: Optional

Max Use: 1

Purpose: To specify the location of the named party

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N301**	**166**	**Address Information** Address information *INDUSTRY:* ***Subscriber Address Line*** **Use this information for the first line of the address information.**	**M**	**AN**	**1/55**
SITUATIONAL	**N302**	**166**	**Address Information** Address information *INDUSTRY:* ***Subscriber Address Line*** **Use this information for the second line of the address information.** **Required if a second address line exists.**	**O**	**AN**	**1/55**

IMPLEMENTATION

SUBSCRIBER CITY/STATE/ZIP CODE

Loop: **2100C — SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Use this segment to identify the city, state and ZIP Code for the subscriber.**
2. **Use of this segment is required if the transaction is not rejected and address information is available from the information source's database.**
3. **Do not return address information from the 270 request.**

Example: **N4*NEW YORK*NY*10003~**

STANDARD

N4 Geographic Location

Level: Detail

Position: 070

Loop: 2100

Requirement: Optional

Max Use: 1

Purpose: To specify the geographic place of the named party

Syntax:

1. **C0605**
   If N406 is present, then N405 is required.

DIAGRAM

N4	*	N401 19 **City Name** O AN 2/30	*	N402 156 **State or Prov Code** O ID 2/2	*	N403 116 **Postal Code** O ID 3/15	*	N404 26 **Country Code** O ID 2/3	*	N405 309 **Location Qualifier** X ID 1/2	*	N406 310 **Location Identifier** O AN 1/30	~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**N401**	**19**	**City Name** Free-form text for city name *INDUSTRY:* ***Subscriber City Name*** **COMMENT:** A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location. **Use this text for the city name of the subscriber's address.**	**O AN 2/30**

SITUATIONAL	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency	**O**	**ID**	**2/2**

INDUSTRY: ***Subscriber State Code***

COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada.

CODE SOURCE 22: States and Outlying Areas of the U.S.

Use this code for the state code of the subscriber's address.

SITUATIONAL	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States)	**O**	**ID**	**3/15**

INDUSTRY: ***Subscriber Postal Zone or ZIP Code***

CODE SOURCE 51: ZIP Code

Use this code for the ZIP or Postal Code of the subscriber's address.

SITUATIONAL	**N404**	**26**	**Country Code** Code identifying the country	**O**	**ID**	**2/3**

CODE SOURCE 5: Countries, Currencies and Funds

Use this code to specify the country of the subscriber's address, if other than the United States.

SITUATIONAL	**N405**	**309**	**Location Qualifier** Code identifying type of location	**X**	**ID**	**1/2**

SYNTAX: C0605

Use if available. Typically only applicable for Medicaid.

CODE	DEFINITION
CY	**County/Parish**
FI	**Federal Information Processing Standards (FIPS) 55 (Named Populated Places)**

CODE SOURCE 43: FIPS-55 (Named Populated Places)

SITUATIONAL	**N406**	**310**	**Location Identifier** Code which identifies a specific location	**O**	**AN**	**1/30**

INDUSTRY: ***Location Identification Code***

SYNTAX: C0605

Use this to identify the location as qualified by the preceding data element (N405).

IMPLEMENTATION

SUBSCRIBER CONTACT INFORMATION

Loop: **2100C — SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **3**

Notes:

1. **Use this segment when needed to identify a contact name and/or communications number for the entity identified. This segment allows for three contact numbers to be listed. This segment is used when the information source wishes to provide a contact for the entity identified in loop 2100C NM1.**

   If telephone extension is sent, it should always be in the occurrence of the communications number following the actual phone number. See the example for an illustration.

2. **If this segment is used, at a minimum either PER02 must be used or PER03 and PER04 must be used. It is recommended that at least PER02, PER03 and PER04 are sent if this segment is used.**

3. **When the communication number represents a telephone number in the United States and other countries using the North American Dialing Plan (for voice, data, fax, etc.), the communication number should always include the area code and phone number using the format AAABBBCCCC. Where AAA is the area code, BBB is the telephone number prefix, and CCCC is the telephone number (e.g. (534)224-2525 would be represented as 5342242525). The extension, when applicable, should be included in the communication number immediately after the telephone number.**

4. **By definition of the standard, if PER03 is used, PER04 is required.**

Example: **PER*IC**HP*2128779765*WP*2127838736*EX*763~**

STANDARD

PER Administrative Communications Contact

Level: Detail

Position: 080

Loop: 2100

Requirement: Optional

Max Use: 3

Purpose: To identify a person or office to whom administrative communications should be directed

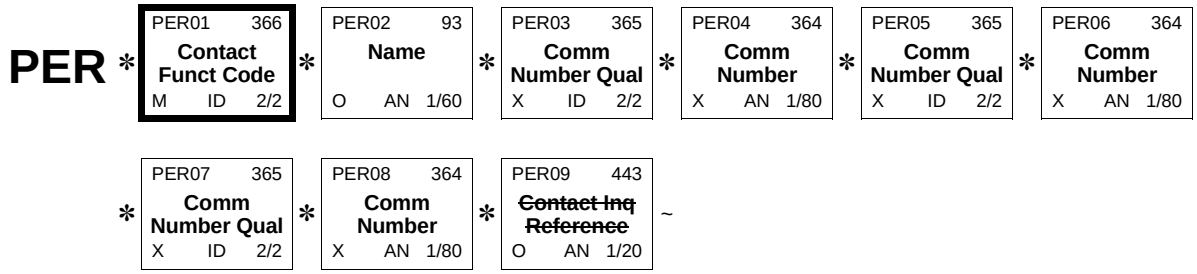
Syntax:

1. **P0304**
   If either PER03 or PER04 is present, then the other is required.

2. **P0506**
   If either PER05 or PER06 is present, then the other is required.

3. P0708
If either PER07 or PER08 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PER01**	**366**	**Contact Function Code** Code identifying the major duty or responsibility of the person or group named **Use this code to specify the type of person or group to which the contact number applies.** CODE / DEFINITION **IC** — **Information Contact**	**M ID 2/2**
SITUATIONAL	**PER02**	**93**	**Name** Free-form name *INDUSTRY:* ***Subscriber Contact Name*** **Use this name for the individual's name or group's name to use when contacting the individual or organization.** **Use this data element when the name of the individual to contact is not already defined or is different than the name within the prior name segment (e.g. N1 or NM1).**	**O AN 1/60**
SITUATIONAL	**PER03**	**365**	**Communication Number Qualifier** Code identifying the type of communication number SYNTAX: P0304 **Use this code to specify what type of communication number is following.** CODE / DEFINITION **HP** — **Home Phone Number** **TE** — **Telephone** **WP** — **Work Phone Number**	**X ID 2/2**

SITUATIONAL	**PER04**	**364**	**Communication Number** Complete communications number including country or area code when applicable	**X**	**AN**	**1/80**

INDUSTRY: ***Subscriber Contact Number***

SYNTAX: P0304

Required when PER02 is not present or when a contact number is to be sent in addition to the contact name. Use this number for the communication number as qualified by the preceding data element.

The format for US domestic phone numbers is:
AAABBBCCCC
AAA = Area Code
BBBCCCC = Local Number

SITUATIONAL	**PER05**	**365**	**Communication Number Qualifier** Code identifying the type of communication number	**X**	**ID**	**2/2**

SYNTAX: P0506

Use this code to specify what type of communication number is following.

CODE	DEFINITION
EX	**Telephone Extension**
HP	**Home Phone Number**
TE	**Telephone**
WP	**Work Phone Number**

SITUATIONAL	**PER06**	**364**	**Communication Number** Complete communications number including country or area code when applicable	**X**	**AN**	**1/80**

INDUSTRY: ***Subscriber Contact Number***

SYNTAX: P0506

Required when an additional contact number is to be sent. Use this number for the communication number as qualified by the preceding data element.

The format for US domestic phone numbers is:
AAABBBCCCC
AAA = Area Code
BBBCCCC = Local Number

SITUATIONAL	**PER07**	**365**	**Communication Number Qualifier** Code identifying the type of communication number	**X**	**ID**	**2/2**

SYNTAX: P0708

Use this code to specify what type of communication number is following.

CODE	DEFINITION
EX	**Telephone Extension**
HP	**Home Phone Number**
TE	**Telephone**

			WP Work Phone Number			
SITUATIONAL	**PER08**	**364**	**Communication Number** Complete communications number including country or area code when applicable *INDUSTRY:* ***Subscriber Contact Number*** SYNTAX: P0708 **Required when an additional contact number is to be sent. Use this number for the communication number as qualified by the preceding data element.**	**X**	**AN**	**1/80**
NOT USED	**PER09**	**443**	**Contact Inquiry Reference**	**O**	**AN**	**1/20**

IMPLEMENTATION

SUBSCRIBER REQUEST VALIDATION

Loop: **2100C — SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **9**

Notes:

1. **Use this segment when a request could not be processed at a system or application level and to indicate what action the originator of the request transaction should take.**

2. **Use this segment to indicate problems in processing the transaction specifically related to the data contained in the original 270 transaction's subscriber name loop (Loop 2100C).**

Example: **AAA*N**72*C~**

STANDARD

AAA Request Validation

Level: Detail

Position: 085

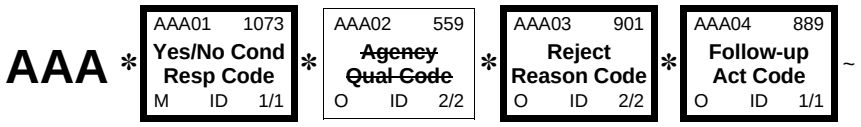
Loop: 2100

Requirement: Optional

Max Use: 9

Purpose: To specify the validity of the request and indicate follow-up action authorized

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AAA01**	**1073**	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response *INDUSTRY:* ***Valid Request Indicator*** **SEMANTIC:** AAA01 designates whether the request is valid or invalid. Code "Y" indicates that the code is valid; code "N" indicates that the code is invalid.	**M ID 1/1**

CODE	DEFINITION
N	**No** **Use this code to indicate that the request or an element in the request is not valid. The transaction has been rejected as identified by the code in AAA03.**

			Y	**Yes** **Use this code to indicate that the request is valid, however the transaction has been rejected as identified by the code in AAA03.**		
NOT USED	**AAA02**	**559**	**Agency Qualifier Code**	**O**	**ID**	**2/2**
REQUIRED	**AAA03**	**901**	**Reject Reason Code** Code assigned by issuer to identify reason for rejection	**O**	**ID**	**2/2**

Use this code for the reason why the transaction was unable to be processed successfully. This may indicate problems with the system, the application, or the data content.

Use codes “43", ”45", “47", ”48", or “51" only in response to information that is in or should be in the PRV segment in the Subscriber Name loop (2100C).

CODE	DEFINITION
15	**Required application data missing**
42	**Unable to Respond at Current Time** **Use this code in a batch environment where an information source returns all requests from the 270 in the 271 and identifies “Unable to Respond at Current Time” for each individual request (subscriber or dependent) within the transaction that they were unable to process for reasons other than data content (such as their system is down or timed out when generating a response).**
43	**Invalid/Missing Provider Identification**
45	**Invalid/Missing Provider Specialty**
47	**Invalid/Missing Provider State**
48	**Invalid/Missing Referring Provider Identification Number**
49	**Provider is Not Primary Care Physician**
51	**Provider Not on File**
52	**Service Dates Not Within Provider Plan Enrollment**
56	**Inappropriate Date**
57	**Invalid/Missing Date(s) of Service**
58	**Invalid/Missing Date-of-Birth**
60	**Date of Birth Follows Date(s) of Service**
61	**Date of Death Precedes Date(s) of Service**
62	**Date of Service Not Within Allowable Inquiry Period**
63	**Date of Service in Future**
64	**Invalid/Missing Patient ID**

			65	Invalid/Missing Patient Name		
			66	Invalid/Missing Patient Gender Code		
			67	Patient Not Found		
			68	Duplicate Patient ID Number		
			71	Patient Birth Date Does Not Match That for the Patient on the Database		
			72	Invalid/Missing Subscriber/Insured ID		
			73	Invalid/Missing Subscriber/Insured Name		
			74	Invalid/Missing Subscriber/Insured Gender Code		
			75	Subscriber/Insured Not Found		
			76	Duplicate Subscriber/Insured ID Number		
			77	Subscriber Found, Patient Not Found		
			78	Subscriber/Insured Not in Group/Plan Identified		
REQUIRED	AAA04	889	**Follow-up Action Code** Code identifying follow-up actions allowed		O ID	1/1
			Use this code to instruct the recipient of the 271 about what action needs to be taken, if any, based on the validity code and the reject reason code (if applicable).			
			CODE	DEFINITION		
			C	Please Correct and Resubmit		
			N	Resubmission Not Allowed		
			R	Resubmission Allowed Use only when AAA03 is “42".		
			S	Do Not Resubmit; Inquiry Initiated to a Third Party		
			W	Please Wait 30 Days and Resubmit		
			X	Please Wait 10 Days and Resubmit		
			Y	Do Not Resubmit; We Will Hold Your Request and Respond Again Shortly Use only when AAA03 is “42".		

IMPLEMENTATION

SUBSCRIBER DEMOGRAPHIC INFORMATION

Loop: **2100C — SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Use this segment to convey the birth date or gender demographic information for the subscriber.**

2. **Use this segment only if the subscriber is the patient and if this information is availalble from the Information Source's database unless a rejection response is generated and the elements were not valued in the request.**

Example: **DMG*D8*19430917*M~**

STANDARD

DMG Demographic Information

Level: Detail

Position: 100

Loop: 2100

Requirement: Optional

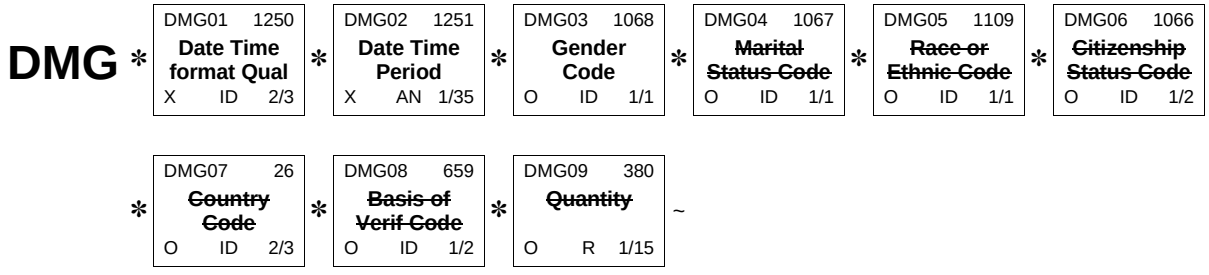
Max Use: 1

Purpose: To supply demographic information

Syntax:

1. **P0102**
   If either DMG01 or DMG02 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
SITUATIONAL	DMG01	1250	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format SYNTAX: P0102 **Use this code to indicate the format of the date of birth that follows in DMG02.** CODE: **D8** — DEFINITION: **Date Expressed in Format CCYYMMDD**	X	ID	2/3
SITUATIONAL	DMG02	1251	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: ***Subscriber Birth Date*** SYNTAX: P0102 SEMANTIC: DMG02 is the date of birth. **Use this date for the date of birth of the individual.** **Required if this is availalble from the Information Source's database unless a rejection response is generated and this element was not valued in the request.**	X	AN	1/35
SITUATIONAL	DMG03	1068	**Gender Code** Code indicating the sex of the individual INDUSTRY: ***Subscriber Gender Code*** **Required if this is availalble from the Information Source's database unless a rejection response is generated and this element was not valued in the request.** CODE: **F** — DEFINITION: **Female** CODE: **M** — DEFINITION: **Male** CODE: **U** — DEFINITION: **Unknown**	O	ID	1/1
NOT USED	DMG04	1067	**Marital Status Code**	O	ID	1/1
NOT USED	DMG05	1109	**Race or Ethnicity Code**	O	ID	1/1
NOT USED	DMG06	1066	**Citizenship Status Code**	O	ID	1/2
NOT USED	DMG07	26	**Country Code**	O	ID	2/3
NOT USED	DMG08	659	**Basis of Verification Code**	O	ID	1/2
NOT USED	DMG09	380	**Quantity**	O	R	1/15

IMPLEMENTATION

SUBSCRIBER RELATIONSHIP

Loop: **2100C — SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Use this segment if necessary to convey insurance related information about the individual identified.**

2. **This segment may also be used to identify that the information source has changed some of the identifying elements for the subscriber that the information receiver submitted in the original 270 transaction.**

3. **Different types of health plans identify patients in different manners depending upon how their eligibility is structured. However, two approaches predominate.**

   The first approach is to assign each individual member of the family (and plan) a unique ID number. This number can be used to identify and access that individual's information independent of whether he or she is a child, spouse, or the actual subscriber to the plan. In this approach, the patient can be identified at the subscriber or insured hierarchical level because a unique ID number exists to access eligibility information for this individual. The relationship of this individual to the actual subscriber or contract holder would be one of spouse, child, self, etc.

   The second approach is to assign the actual subscriber or contract holder a unique ID number that is entered into the eligibility system. Any related spouse, children, or dependents are identified through the subscriber's ID and have no unique identification number of their own. In this approach, the subscriber would be identified at the Loop 2100C subscriber or insured level, and the actual patient (spouse, child, etc.) would be identified at the Loop 2100D dependent level under the subscriber.

Example: **INS*Y*18*001*25~**

STANDARD

INS Insured Benefit

Level: Detail

Position: 110

Loop: 2100

Requirement: Optional

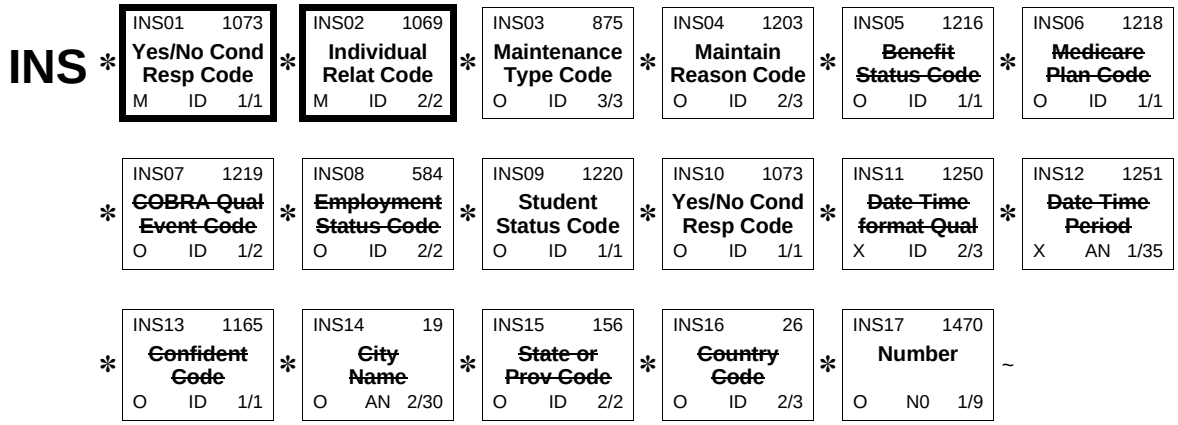
Max Use: 1

Purpose: To provide benefit information on insured entities

Syntax:

1. **P1112**
   If either INS11 or INS12 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**INS01**	**1073**	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response *INDUSTRY:* ***Insured Indicator*** **SEMANTIC:** INS01 indicates status of the insured. A "Y" value indicates the insured is a subscriber: an "N" value indicates the insured is a dependent.	**M ID 1/1**
			CODE **DEFINITION** **Y** **Yes**	
REQUIRED	**INS02**	**1069**	**Individual Relationship Code** Code indicating the relationship between two individuals or entities	**M ID 2/2**
			CODE **DEFINITION** **18** **Self**	
SITUATIONAL	**INS03**	**875**	**Maintenance Type Code** Code identifying the specific type of item maintenance **Use this element (and code "25" in INS04) if any of the identifying elements for the subscriber have been changed from those submitted in the 270.**	**O ID 3/3**
			CODE **DEFINITION** **001** **Change**	

SITUATIONAL	**INS04**	**1203**	**Maintenance Reason Code** Code identifying the reason for the maintenance change	**O**	**ID**	**2/3**

Use this element (and code "001" in INS03) if any of the identifying elements for the subscriber have been changed from those submitted in the 270.

CODE	DEFINITION
25	**Change in Indentifying Data Elements** **Use this code to indicate that a change has been made to the primary elements that identify a specific person. Such elements are first name, last name, date of birth, identification numbers, and address.**

NOT USED	**INS05**	**1216**	**Benefit Status Code**	**O**	**ID**	**1/1**
NOT USED	**INS06**	**1218**	**Medicare Plan Code**	**O**	**ID**	**1/1**
NOT USED	**INS07**	**1219**	**Consolidated Omnibus Budget Reconciliation Act (COBRA) Qualifying**	**O**	**ID**	**1/2**
NOT USED	**INS08**	**584**	**Employment Status Code**	**O**	**ID**	**2/2**
SITUATIONAL	**INS09**	**1220**	**Student Status Code** Code indicating the student status of the patient if 19 years of age or older, not handicapped and not the insured	**O**	**ID**	**1/1**

Use if available.

CODE	DEFINITION
F	**Full-time**
N	**Not a Student**
P	**Part-time**

SITUATIONAL	**INS10**	**1073**	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response	**O**	**ID**	**1/1**

INDUSTRY: ***Handicap Indicator***

SEMANTIC: INS10 is the handicapped status indicator. A "Y" value indicates an individual is handicapped; an "N" value indicates an individual is not handicapped.

Use if available.

CODE	DEFINITION
N	**No**
Y	**Yes**

NOT USED	**INS11**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**INS12**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**INS13**	**1165**	**Confidentiality Code**	**O**	**ID**	**1/1**
NOT USED	**INS14**	**19**	**City Name**	**O**	**AN**	**2/30**
NOT USED	**INS15**	**156**	**State or Province Code**	**O**	**ID**	**2/2**
NOT USED	**INS16**	**26**	**Country Code**	**O**	**ID**	**2/3**

SITUATIONAL	**INS17**	**1470**	**Number** A generic number	**O**	**N0**	**1/9**

INDUSTRY: ***Birth Sequence Number***

SEMANTIC: INS17 is the number assigned to each family member born with the same birth date. This number identifies birth sequence for multiple births allowing proper tracking and response of benefits for each dependent (i.e., twins, triplets, etc.).

Use to indicate the birth order in the event of multiple birth's in association with the birth date supplied in DMG02.

IMPLEMENTATION

SUBSCRIBER DATE

Loop: **2100C — SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **9**

Notes:

1. **Use this segment to convey any relevant dates. The dates represented may be in the past, the current date, or a future date. The dates may also be a single date or a span of dates. Which date(s) to use is determined by the format qualifier in DTP02.**

2. **When using codes "307" (Eligibility), "356" (Eligibility Begin), "357" (Eligibility End), "435" (Admission) or "472" (Service) at this level, it is implied that these dates apply to all of the Eligibility or Benefit Information (EB) loops that follow.**

Example: **DTP*346*D8*19950818~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 120

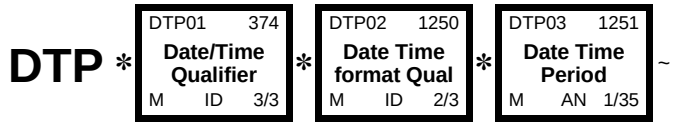
Loop: 2100

Requirement: Optional

Max Use: 9

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time	**M ID 3/3**

INDUSTRY: ***Date Time Qualifier***

CODE	DEFINITION
102	**Issue**
152	**Effective Date of Change**
291	**Plan**
307	**Eligibility**

			318	**Added**			
			340	**Consolidated Omnibus Budget Reconciliation Act (COBRA) Begin**			
			341	**Consolidated Omnibus Budget Reconciliation Act (COBRA) End**			
			342	**Premium Paid to Date Begin**			
			343	**Premium Paid to Date End**			
			346	**Plan Begin**			
			347	**Plan End**			
			356	**Eligibility Begin**			
			357	**Eligibility End**			
			382	**Enrollment**			
			435	**Admission**			
			442	**Date of Death**			
			458	**Certification**			
			472	**Service**			
			539	**Policy Effective**			
			540	**Policy Expiration**			
			636	**Date of Last Update**			
			771	**Status**			
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier**		**M**	**ID**	**2/3**
			Code indicating the date format, time format, or date and time format				
			SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03.				
			Use this code to specify the format of the date(s)/time(s) that follow in the next data element.				
			CODE	**DEFINITION**			
			D8	**Date Expressed in Format CCYYMMDD**			
			RD8	**Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD**			
REQUIRED	**DTP03**	**1251**	**Date Time Period**		**M**	**AN**	**1/35**
			Expression of a date, a time, or range of dates, times or dates and times				
			Use this date for the date(s) as qualified by the preceding data elements.				

IMPLEMENTATION

SUBSCRIBER ELIGIBILITY OR BENEFIT INFORMATION

Loop: 2110C — SUBSCRIBER ELIGIBILITY OR BENEFIT INFORMATION
Repeat: >1

Usage: SITUATIONAL

Repeat: 1

Notes:

1. Use this segment to begin the eligibility/benefit information looping structure. The EB segment is used to convey the specific eligibility or benefit information for the entity identified.

2. This segment is required if the subscriber is the person whose eligibility or benefits are being described and the transaction is not rejected (see Section 1.3.9) or if the transaction needs to be rejected in this loop.

3. When the subscriber is not the person whose eligibility or benefits are being described, this loop must not be used.

4. A limit to the number of repeats of EB loops has not been established. In a batch environment there is no practical reason to limit the number of EB loop repeats. In a real time environment, consideration should be given to how many EB loops are generated given the amount of time it takes to format the response and the amount of time it will take to transmit that response. Since these limitations will vary by information source, it would be completely arbitrary for the developers to set a limit. It is not the intent of the developers to limit the amount of information that is returned in a response, rather to alert information sources to consider the potential delays if the response contains too much information to be formatted and transmitted in real time.

5. The minimum data for a HIPAA compliant response for a person that has been located in the information source's system must indicate either, 1- Active Coverage or 6 - Inactive in EB01 and, 30 - Health Benefit Plan Coverage in EB03. Information sources are not limited to the minimum HIPAA compliant response and are highly encouraged to create as elaborate a response their systems allow. See section 1.3.7 HIPAA Compliant Use of the 270/271 Transaction Set for additional information.

Example: EB*1*FAM*96*GP~

Example: EB*B**98***27*10**VS*1~

Example: EB*C*IND****23*200~

Example: EB*C*FAM****23*600~

Example: EB*A**A6*****.50~

Example: EB*L~

STANDARD

EB Eligibility or Benefit Information

Level: Detail

Position: 130

Loop: 2110 **Repeat:** >1

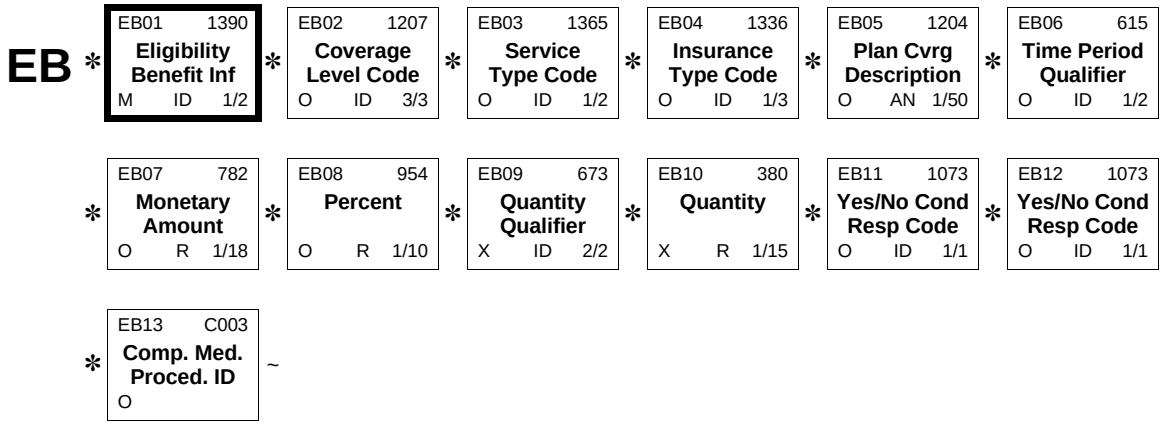
Requirement: Optional

Max Use: 1

Purpose: To supply eligibility or benefit information

Syntax: **1. P0910**
If either EB09 or EB10 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**EB01**	**1390**	**Eligibility or Benefit Information** Code identifying eligibility or benefit information SEMANTIC: EB01 qualifies EB06 through EB10. **Use this code to identify the eligibility or benefit information. This may be the eligibility status of the individual or the benefit related category that is being further described in the following data elements. This data element also qualifies the data in elements EB06 through EB10.**	**M ID 1/2**

CODE	DEFINITION
1	**Active Coverage**
2	**Active - Full Risk Capitation**
3	**Active - Services Capitated**

4	Active - Services Capitated to Primary Care Physician
5	Active - Pending Investigation
6	Inactive
7	Inactive - Pending Eligibility Update
8	Inactive - Pending Investigation
A	Co-Insurance
B	Co-Payment
C	Deductible
CB	Coverage Basis
D	Benefit Description
E	Exclusions
F	Limitations
G	Out of Pocket (Stop Loss)
H	Unlimited
I	Non-Covered
J	Cost Containment
K	Reserve
L	Primary Care Provider
M	Pre-existing Condition
MC	Managed Care Coordinator
N	Services Restricted to Following Provider
O	Not Deemed a Medical Necessity
P	Benefit Disclaimer Not recommended. See section 1.3.10 Disclaimers Within the Transaction.
Q	Second Surgical Opinion Required
R	Other or Additional Payor
S	Prior Year(s) History
T	Card(s) Reported Lost/Stolen
U	Contact Following Entity for Eligibility or Benefit Information
V	Cannot Process

W	Other Source of Data
X	Health Care Facility
Y	Spend Down

SITUATIONAL **EB02** **1207** **Coverage Level Code** **O** **ID** **3/3**
Code indicating the level of coverage being provided for this insured

INDUSTRY: ***Benefit Coverage Level Code***

Use this code to identify the level of coverage of benefits. It identifies the types and number of entities that are covered by the insurance plan.

Use if available.

CODE	DEFINITION
CHD	Children Only
DEP	Dependents Only
ECH	Employee and Children
EMP	Employee Only
ESP	Employee and Spouse
FAM	Family
IND	Individual
SPC	Spouse and Children
SPO	Spouse Only

SITUATIONAL **EB03** **1365** **Service Type Code** **O** **ID** **1/2**
Code identifying the classification of service

If a service type code is sent by an information receiver that is not supported by the information source, the information source must respond with at least a service type code of 30 - Health Benefit Plan Coverage. See EB segment notes and section 1.3.7 HIPAA Compliant Use of the 270/271 Transaction Set for additional information. Information receivers need to be made aware that receipt of a 271 response with a Service Type Code of 30 indicates that the information source may not be able to process an explicit request and the response does not indicate coverage of a specific benefit if one was sent in the 270 request.

If a very specific type or category of service for which eligibility or benefits can be described, use one of the codes from the full list.

CODE	DEFINITION
1	Medical Care
2	Surgical
3	Consultation
4	Diagnostic X-Ray

5	Diagnostic Lab
6	Radiation Therapy
7	Anesthesia
8	Surgical Assistance
9	Other Medical
10	Blood Charges
11	Used Durable Medical Equipment
12	Durable Medical Equipment Purchase
13	Ambulatory Service Center Facility
14	Renal Supplies in the Home
15	Alternate Method Dialysis
16	Chronic Renal Disease (CRD) Equipment
17	Pre-Admission Testing
18	Durable Medical Equipment Rental
19	Pneumonia Vaccine
20	Second Surgical Opinion
21	Third Surgical Opinion
22	Social Work
23	Diagnostic Dental
24	Periodontics
25	Restorative
26	Endodontics
27	Maxillofacial Prosthetics
28	Adjunctive Dental Services
30	Health Benefit Plan Coverage Use this code if only a single category of benefits can be supported.
32	Plan Waiting Period
33	Chiropractic
34	Chiropractic Office Visits
35	Dental Care
36	Dental Crowns
37	Dental Accident

38	Orthodontics
39	Prosthodontics
40	Oral Surgery
41	Routine (Preventive) Dental
42	Home Health Care
43	Home Health Prescriptions
44	Home Health Visits
45	Hospice
46	Respite Care
47	Hospital
48	Hospital - Inpatient
49	Hospital - Room and Board
50	Hospital - Outpatient
51	Hospital - Emergency Accident
52	Hospital - Emergency Medical
53	Hospital - Ambulatory Surgical
54	Long Term Care
55	Major Medical
56	Medically Related Transportation
57	Air Transportation
58	Cabulance
59	Licensed Ambulance
60	General Benefits
61	In-vitro Fertilization
62	MRI/CAT Scan
63	Donor Procedures
64	Acupuncture
65	Newborn Care
66	Pathology
67	Smoking Cessation
68	Well Baby Care

69	Maternity
70	Transplants
71	Audiology Exam
72	Inhalation Therapy
73	Diagnostic Medical
74	Private Duty Nursing
75	Prosthetic Device
76	Dialysis
77	Otological Exam
78	Chemotherapy
79	Allergy Testing
80	Immunizations
81	Routine Physical
82	Family Planning
83	Infertility
84	Abortion
85	AIDS
86	Emergency Services
87	Cancer
88	Pharmacy
89	Free Standing Prescription Drug
90	Mail Order Prescription Drug
91	Brand Name Prescription Drug
92	Generic Prescription Drug
93	Podiatry
94	Podiatry - Office Visits
95	Podiatry - Nursing Home Visits
96	Professional (Physician)
97	Anesthesiologist
98	Professional (Physician) Visit - Office
99	Professional (Physician) Visit - Inpatient
A0	Professional (Physician) Visit - Outpatient

A1	Professional (Physician) Visit - Nursing Home
A2	Professional (Physician) Visit - Skilled Nursing Facility
A3	Professional (Physician) Visit - Home
A4	Psychiatric
A5	Psychiatric - Room and Board
A6	Psychotherapy
A7	Psychiatric - Inpatient
A8	Psychiatric - Outpatient
A9	Rehabilitation
AA	Rehabilitation - Room and Board
AB	Rehabilitation - Inpatient
AC	Rehabilitation - Outpatient
AD	Occupational Therapy
AE	Physical Medicine
AF	Speech Therapy
AG	Skilled Nursing Care
AH	Skilled Nursing Care - Room and Board
AI	Substance Abuse
AJ	Alcoholism
AK	Drug Addiction
AL	Vision (Optometry)
AM	Frames
AN	Routine Exam
AO	Lenses
AQ	Nonmedically Necessary Physical
AR	Experimental Drug Therapy
BA	Independent Medical Evaluation
BB	Partial Hospitalization (Psychiatric)
BC	Day Care (Psychiatric)
BD	Cognitive Therapy
BE	Massage Therapy

			BF	Pulmonary Rehabilitation
			BG	Cardiac Rehabilitation
			BH	Pediatric
			BI	Nursery
			BJ	Skin
			BK	Orthopedic
			BL	Cardiac
			BM	Lymphatic
			BN	Gastrointestinal
			BP	Endocrine
			BQ	Neurology
			BR	Eye
			BS	Invasive Procedures
SITUATIONAL	EB04	1336	**Insurance Type Code** O ID 1/3 Code identifying the type of insurance policy within a specific insurance program **Use if available.**	

CODE	DEFINITION
12	Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan
13	Medicare Secondary End-Stage Renal Disease Beneficiary in the 12 month coordination period with an employer's group health plan
14	Medicare Secondary, No-fault Insurance including Auto is Primary
15	Medicare Secondary Worker's Compensation
16	Medicare Secondary Public Health Service (PHS)or Other Federal Agency
41	Medicare Secondary Black Lung
42	Medicare Secondary Veteran's Administration
43	Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)
47	Medicare Secondary, Other Liability Insurance is Primary
AP	Auto Insurance Policy
C1	Commercial

CO	Consolidated Omnibus Budget Reconciliation Act (COBRA)
CP	Medicare Conditionally Primary
D	Disability
DB	Disability Benefits
EP	Exclusive Provider Organization
FF	Family or Friends
GP	Group Policy
HM	Health Maintenance Organization (HMO)
HN	Health Maintenance Organization (HMO) - Medicare Risk
HS	Special Low Income Medicare Beneficiary
IN	Indemnity
IP	Individual Policy
LC	Long Term Care
LD	Long Term Policy
LI	Life Insurance
LT	Litigation
MA	Medicare Part A
MB	Medicare Part B
MC	Medicaid
MH	Medigap Part A
MI	Medigap Part B
MP	Medicare Primary
OT	Other
PE	Property Insurance - Personal
PL	Personal
PP	Personal Payment (Cash - No Insurance)
PR	Preferred Provider Organization (PPO)
PS	Point of Service (POS)
QM	Qualified Medicare Beneficiary
RP	Property Insurance - Real
SP	Supplemental Policy

			TF	**Tax Equity Fiscal Responsibility Act (TEFRA)**		
			WC	**Workers Compensation**		
			WU	**Wrap Up Policy**		
SITUATIONAL	**EB05**	**1204**	**Plan Coverage Description** A description or number that identifies the plan or coverage	**O**	**AN**	**1/50**
			Use this free-form text area to convey the specific product name for an insurance plan.			
			Use if available.			
SITUATIONAL	**EB06**	**615**	**Time Period Qualifier** Code defining periods	**O**	**ID**	**1/2**
			Use this code for the time period category for the benefits being described when needed to qualify benefit availability.			

CODE	DEFINITION
6	**Hour**
7	**Day**
13	**24 Hours**
21	**Years**
22	**Service Year**
23	**Calendar Year**
24	**Year to Date**
25	**Contract**
26	**Episode**
27	**Visit**
28	**Outlier**
29	**Remaining**
30	**Exceeded**
31	**Not Exceeded**
32	**Lifetime**
33	**Lifetime Remaining**
34	**Month**
35	**Week**
36	**Admisson**

SITUATIONAL	**EB07**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***Benefit Amount***

Use this monetary amount as qualified by EB01.

Use if eligibility or benefit must be qualified by a monetary amount; e.g., deductible, co-payment.

SITUATIONAL	**EB08**	**954**	**Percent** Percentage expressed as a decimal	**O**	**R**	**1/10**

INDUSTRY: ***Benefit Percent***

Use this percentage rate as qualified by EB01.

Use if eligibility or benefit must be qualified by a percentage; e.g., co-insurance.

SITUATIONAL	**EB09**	**673**	**Quantity Qualifier** Code specifying the type of quantity	**X**	**ID**	**2/2**

SYNTAX: P0910

Use this code to identify the type of units that are being conveyed in the following data element (EB10).

CODE	DEFINITION
99	**Quantity Used**
CA	**Covered - Actual**
CE	**Covered - Estimated**
DB	**Deductible Blood Units**
DY	**Days**
HS	**Hours**
LA	**Life-time Reserve - Actual**
LE	**Life-time Reserve - Estimated**
MN	**Month**
P6	**Number of Services or Procedures**
QA	**Quantity Approved**
S7	**Age, High Value** **Use this code when a benefit is based on a maximum age for the patient.**
S8	**Age, Low Value** **Use this code when a benefit is based on a minimum age for the patient.**
VS	**Visits**
YY	**Years**

SITUATIONAL	**EB10**	**380**	**Quantity** Numeric value of quantity	**X**	**R**	**1/15**

INDUSTRY: ***Benefit Quantity***

SYNTAX: P0910

Use this number for the quantity value as qualified by the preceding data element (EB09).

SITUATIONAL	**EB11**	**1073**	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response	**O**	**ID**	**1/1**

INDUSTRY: ***Authorization or Certification Indicator***

SEMANTIC: EB11 is the authorization or certification indicator. A "Y" value indicates that an authorization or certification is required per plan provisions. An "N" value indicates that an authorization or certification is not required per plan provisions. A "U" value indicates it is unknown whether the plan provisions require an authorization or certification.

Use if it is necessary to indicate if authorization or certification is required.

CODE	DEFINITION
N	**No**
U	**Unknown**
Y	**Yes**

SITUATIONAL	**EB12**	**1073**	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response	**O**	**ID**	**1/1**

INDUSTRY: ***In Plan Network Indicator***

SEMANTIC: EB12 is the plan network indicator. A "Y" value indicates the benefits identified are considered In-Plan-Network. An "N" value indicates that the benefits identified are considered Out-Of-Plan-Network. A "U" value indicates it is unknown whether the benefits identified are part of the Plan Network.

Use if it is necessary to indicate if benefits are considered In or Out of Plan-Network or not.

CODE	DEFINITION
N	**No**
U	**Unknown**
Y	**Yes**

SITUATIONAL	**EB13**	**C003**	**COMPOSITE MEDICAL PROCEDURE IDENTIFIER** To identify a medical procedure by its standardized codes and applicable modifiers	**O**		

Use this composite data element only if an information source can support this high level of functionality. The EB13 allows for a very specific response to a very specific inquiry, such as based on a diagnosis or a procedure code. This element is only recommended when responding to an inquiry that contained related EQ02 data.

REQUIRED **EB13 - 1** **235** **Product/Service ID Qualifier** **M ID 2/2**
Code identifying the type/source of the descriptive number used in Product/Service ID (234)

INDUSTRY: ***Product or Service ID Qualifier***

Use this code to identify the external code list of the following procedure/service code.

CODE	DEFINITION
AD	**American Dental Association Codes**
	CODE SOURCE 135: American Dental Association Codes
CJ	**Current Procedural Terminology (CPT) Codes**
	CODE SOURCE 133: Current Procedural Terminology (CPT) Codes
HC	**Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes**
	CODE SOURCE 130: Health Care Financing Administration Common Procedural Coding System
ID	**International Classification of Diseases Clinical Modification (ICD-9-CM) - Procedure**
	CODE SOURCE 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure
ND	**National Drug Code (NDC)**
	CODE SOURCE 134: National Drug Code
ZZ	**Mutually Defined** **NOT ADVISED** **Use this code only for local codes or interim uses until an appropriate new code is approved.**

REQUIRED **EB13 - 2** **234** **Product/Service ID** **M AN 1/48**
Identifying number for a product or service

INDUSTRY: ***Procedure Code***

Use this ID number for the product/service code as qualified by the preceding data element.

SITUATIONAL **EB13 - 3** **1339** **Procedure Modifier** **O AN 2/2**
This identifies special circumstances related to the performance of the service, as defined by trading partners

Use this modifier for the procedure code identified in EB13-2 if modifiers are needed to further specify the service.

SITUATIONAL **EB13 - 4** **1339** **Procedure Modifier** **O AN 2/2**
This identifies special circumstances related to the performance of the service, as defined by trading partners

Use this modifier for the procedure code identified in EB13-2 if modifiers are needed to further specify the service.

SITUATIONAL **EB13 - 5** **1339** **Procedure Modifier** **O AN 2/2**
This identifies special circumstances related to the performance of the service, as defined by trading partners

Use this modifier for the procedure code identified in EB13-2 if modifiers are needed to further specify the service.

SITUATIONAL	**EB13 - 6**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners **Use this modifier for the procedure code identified in EB13-2 if modifiers are needed to further specify the service.**	**O**	**AN**	**2/2**
NOT USED	**EB13 - 7**	**352**	**Description**	**O**	**AN**	**1/80**

IMPLEMENTATION

HEALTH CARE SERVICES DELIVERY

Loop: **2110C — SUBSCRIBER ELIGIBILITY OR BENEFIT INFORMATION**

Usage: **SITUATIONAL**

Repeat: **9**

Notes:
1. **Use this segment only when benefits identified in either EB03 or EB13 have a specific delivery or usage pattern associated with the benefit.**

Example: **HSD*VS*30***22~**
Thirty visits per service year

Example: **HSD*VS*12*WK*3*34*1~**
Twelve visits, three visits per week, for 1 month.

STANDARD

HSD Health Care Services Delivery

Level: Detail

Position: 135

Loop: 2110

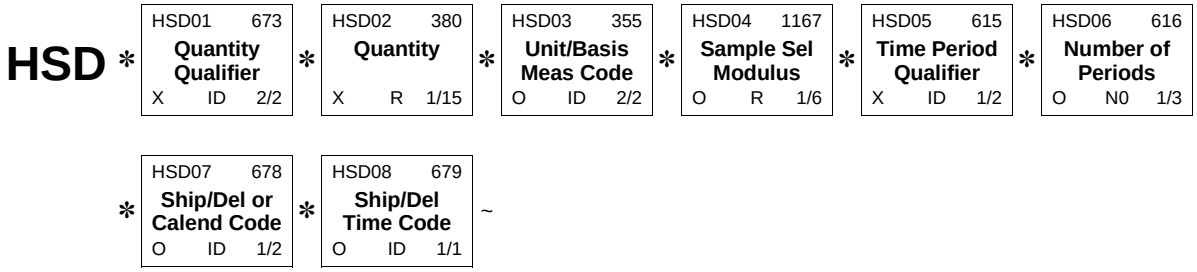
Requirement: Optional

Max Use: 9

Purpose: To specify the delivery pattern of health care services

Syntax:
1. **P0102**
   If either HSD01 or HSD02 is present, then the other is required.
2. **C0605**
   If HSD06 is present, then HSD05 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	HSD01	673	**Quantity Qualifier** Code specifying the type of quantity SYNTAX: P0102 **Required if identifying type and quantity of benefits.** **Required if HSD02 is used.**	X ID 2/2
			CODE / DEFINITION DY Days FL Units HS Hours MN Month VS Visits	
SITUATIONAL	HSD02	380	**Quantity** Numeric value of quantity *INDUSTRY: **Benefit Quantity*** SYNTAX: P0102 **Required if identifying type and quantity of benefits.** **Required if HSD01 is used.**	X R 1/15
SITUATIONAL	HSD03	355	**Unit or Basis for Measurement Code** Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken **Used if needed to provide further information about the number and frequency of benefits.**	O ID 2/2
			CODE / DEFINITION DA Days MO Months VS Visit WK Week YR Years	
SITUATIONAL	HSD04	1167	**Sample Selection Modulus** To specify the sampling frequency in terms of a modulus of the Unit of Measure, e.g., every fifth bag, every 1.5 minutes **Used if needed to provide further information about the number and frequency of benefits.**	O R 1/6

SITUATIONAL **HSD05** **615** **Time Period Qualifier** **X** **ID** **1/2**
Code defining periods

SYNTAX: C0605

Used if needed to provide further information about the number and frequency of benefits.

CODE	DEFINITION
6	Hour
7	Day
21	Years
22	Service Year
23	Calendar Year
24	Year to Date
25	Contract
26	Episode
27	Visit
28	Outlier
29	Remaining
30	Exceeded
31	Not Exceeded
32	Lifetime
33	Lifetime Remaining
34	Month
35	Week

SITUATIONAL **HSD06** **616** **Number of Periods** **O** **N0** **1/3**
Total number of periods

INDUSTRY: ***Period Count***

SYNTAX: C0605

Used if needed to provide further information about the number and frequency of benefits.

SITUATIONAL **HSD07** **678** **Ship/Delivery or Calendar Pattern Code** **O** **ID** **1/2**
Code which specifies the routine shipments, deliveries, or calendar pattern

INDUSTRY: ***Delivery Frequency Code***

Used if needed to provide further information about the number and frequency of benefits.

CODE	DEFINITION
1	1st Week of the Month
2	2nd Week of the Month

3	3rd Week of the Month
4	4th Week of the Month
5	5th Week of the Month
6	1st & 3rd Weeks of the Month
7	2nd & 4th Weeks of the Month
8	1st Working Day of Period
9	Last Working Day of Period
A	Monday through Friday
B	Monday through Saturday
C	Monday through Sunday
D	Monday
E	Tuesday
F	Wednesday
G	Thursday
H	Friday
J	Saturday
K	Sunday
L	Monday through Thursday
M	Immediately
N	As Directed
O	Daily Mon. through Fri.
P	1/2 Mon. & 1/2 Thurs.
Q	1/2 Tues. & 1/2 Thurs.
R	1/2 Wed. & 1/2 Fri.
S	Once Anytime Mon. through Fri.
SG	Tuesday through Friday
SL	Monday, Tuesday and Thursday
SP	Monday, Tuesday and Friday
SX	Wednesday and Thursday
SY	Monday, Wednesday and Thursday
SZ	Tuesday, Thursday and Friday

T	1/2 Tue. & 1/2 Fri.
U	1/2 Mon. & 1/2 Wed.
V	1/3 Mon., 1/3 Wed., 1/3 Fri.
W	Whenever Necessary
X	1/2 By Wed., Bal. By Fri.
Y	None (Also Used to Cancel or Override a Previous Pattern)

SITUATIONAL **HSD08** **679** **Ship/Delivery Pattern Time Code** **O** **ID** **1/1**
Code which specifies the time for routine shipments or deliveries

INDUSTRY: ***Delivery Pattern Time Code***

Used if needed to provide further information about the number and frequency of benefits.

CODE	DEFINITION
A	1st Shift (Normal Working Hours)
B	2nd Shift
C	3rd Shift
D	A.M.
E	P.M.
F	As Directed
G	Any Shift
Y	None (Also Used to Cancel or Override a Previous Pattern)

IMPLEMENTATION

SUBSCRIBER ADDITIONAL IDENTIFICATION

Loop: **2110C — SUBSCRIBER ELIGIBILITY OR BENEFIT INFORMATION**

Usage: **SITUATIONAL**

Repeat: **9**

Notes:
1. **Use this segment to identify other or additional reference numbers for the entity identified. The type of reference number is determined by the qualifier in REF01.**
2. **Use this segment for reference identifiers related only to the EB loop that it is contained in (e.g. Other or Additional Payer's identifiers).**

Example: **REF*G1*653745725~**

STANDARD

REF Reference Identification

Level: Detail

Position: 140

Loop: 2110

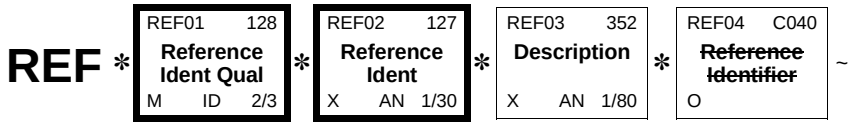
Requirement: Optional

Max Use: 9

Purpose: To specify identifying information

Syntax:
1. **R0203**
   At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**
			Use this code to specify or qualify the type of reference number that is following in REF02, REF03, or both.	
			Use "1L", "1W", "18", "49", "6P'', "A6", "F6", "IG'', "N6", and "NQ" only in an EB loop with EB01 = "R".	

CODE	DEFINITION
18	**Plan Number**

			1L	**Group or Policy Number** **Use this code only if it cannot be determined if the number is a Group Number or a Policy number. Use codes "IG" or "6P" when they can be determined.**			
			1W	**Member Identification Number**			
			49	**Family Unit Number**			
			6P	**Group Number**			
			9F	**Referral Number**			
			A6	**Employee Identification Number**			
			F6	**Health Insurance Claim (HIC) Number**			
			G1	**Prior Authorization Number**			
			IG	**Insurance Policy Number**			
			N6	**Plan Network Identification Number**			
			NQ	**Medicaid Recipient Identification Number**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Subscriber Eligibility or Benefit Identifier*** SYNTAX: R0203 **Use this information for the reference number as qualified by the preceding data element (REF01).**	**X**	**AN**	**1/30**
SITUATIONAL	**REF03**	**352**	**Description** A free-form description to clarify the related data elements and their content *INDUSTRY:* ***Plan Sponsor Name*** SYNTAX: R0203 **Use if available.**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

SUBSCRIBER ELIGIBILITY/BENEFIT DATE

Loop: **2110C — SUBSCRIBER ELIGIBILITY OR BENEFIT INFORMATION**

Usage: **SITUATIONAL**

Repeat: **20**

Notes:

1. **Use this segment to convey dates associated with the information contained in the corresponding Eligibility or Benefit Information (EB) loop.**

2. **When using codes “307" (Eligibility), ”435" (Admission) or “472" (Service) at this level, it is implied that these dates apply only to the Eligibility or Benefit Information (EB) loop that it is located in. If there is a need to supply a global Eligibility, Admission or Service date, it must be provided in the DTP segment within the Subscriber Name (Loop 2100C) loop.**

Example: **DTP*472*D8*19960624~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 150

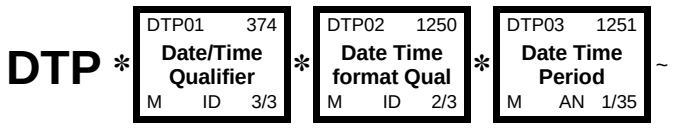
Loop: 2110

Requirement: Optional

Max Use: 20

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time	**M ID 3/3**

INDUSTRY: ***Date Time Qualifier***

CODE	DEFINITION
193	**Period Start**
194	**Period End**
198	**Completion**
290	**Coordination of Benefits**

			292	**Benefit**			
			295	**Primary Care Provider**			
			304	**Latest Visit or Consultation**			
			307	**Eligibility**			
			318	**Added**			
			348	**Benefit Begin**			
			349	**Benefit End**			
			356	**Eligibility Begin**			
			357	**Eligibility End**			
			435	**Admission**			
			472	**Service**			
			636	**Date of Last Update**			

REQUIRED **DTP02** **1250** **Date Time Period Format Qualifier** **M** **ID** **2/3**

Code indicating the date format, time format, or date and time format

SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03.

Use this code to specify the format of the date(s)/time(s) that follow in the next data element.

CODE	DEFINITION
D8	**Date Expressed in Format CCYYMMDD**
RD8	**Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD**

REQUIRED **DTP03** **1251** **Date Time Period** **M** **AN** **1/35**

Expression of a date, a time, or range of dates, times or dates and times

INDUSTRY: ***Eligibility or Benefit Date Time Period***

Use this date for the date(s) as qualified by the preceding data elements.

IMPLEMENTATION

SUBSCRIBER REQUEST VALIDATION

Loop: **2110C — SUBSCRIBER ELIGIBILITY OR BENEFIT INFORMATION**

Usage: **SITUATIONAL**

Repeat: **9**

Notes:

1. **Use this segment when a request could not be processed at a system or application level and to indicate what action the originator of the request transaction should take.**

2. **Use this segment to indicate problems in processing the transaction specifically related to specific eligibility/benefit inquiry data contained in the original 270 transaction's subscriber eligibility/benefit inquiry information loop (Loop 2110C).**

Example: **AAA*N**70*C~**

STANDARD

AAA Request Validation

Level: Detail

Position: 160

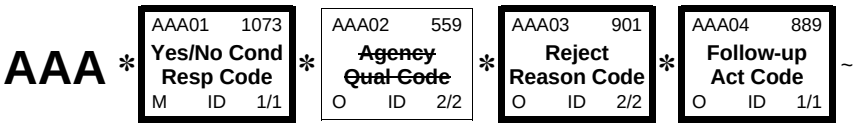
Loop: 2110

Requirement: Optional

Max Use: 9

Purpose: To specify the validity of the request and indicate follow-up action authorized

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AAA01**	**1073**	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response	**M ID 1/1**

INDUSTRY: ***Valid Request Indicator***

SEMANTIC: AAA01 designates whether the request is valid or invalid. Code "Y" indicates that the code is valid; code "N" indicates that the code is invalid.

CODE	DEFINITION
N	**No** **Use this code to indicate that the request or an element in the request is not valid. The transaction has been rejected as identified by the code in AAA03.**

			Y	**Yes** **Use this code to indicate that the request is valid, however the transaction has been rejected as identified by the code in AAA03.**		
NOT USED	**AAA02**	**559**	**Agency Qualifier Code**	**O**	**ID**	**2/2**
REQUIRED	**AAA03**	**901**	**Reject Reason Code** Code assigned by issuer to identify reason for rejection	**O**	**ID**	**2/2**

Use this code for the reason why the transaction was unable to be processed successfully. This may indicate problems with the system, the application, or the data content.

CODE	DEFINITION
15	**Required application data missing**
52	**Service Dates Not Within Provider Plan Enrollment**
53	**Inquired Benefit Inconsistent with Provider Type**
54	**Inappropriate Product/Service ID Qualifier**
55	**Inappropriate Product/Service ID**
56	**Inappropriate Date**
57	**Invalid/Missing Date(s) of Service**
60	**Date of Birth Follows Date(s) of Service**
61	**Date of Death Precedes Date(s) of Service**
62	**Date of Service Not Within Allowable Inquiry Period**
63	**Date of Service in Future**
69	**Inconsistent with Patient's Age**
70	**Inconsistent with Patient's Gender**

REQUIRED	**AAA04**	**889**	**Follow-up Action Code** Code identifying follow-up actions allowed	**O**	**ID**	**1/1**

Use this code to instruct the recipient of the 271 about what action needs to be taken, if any, based on the validity code and the reject reason code (if applicable).

CODE	DEFINITION
C	**Please Correct and Resubmit**
N	**Resubmission Not Allowed**
R	**Resubmission Allowed**
W	**Please Wait 30 Days and Resubmit**
X	**Please Wait 10 Days and Resubmit**
Y	**Do Not Resubmit; We Will Hold Your Request and Respond Again Shortly**

IMPLEMENTATION

MESSAGE TEXT

Loop: **2110C — SUBSCRIBER ELIGIBILITY OR BENEFIT INFORMATION**

Usage: **SITUATIONAL**

Repeat: **10**

Advisory: **Under most circumstances, this segment is not sent.**

Notes:

1. **Free form text or description fields are not recommended because they require human interpretation.**

2. **Under no circumstances can an information source use the MSG segment to relay information that can be sent using codified information in existing data elements. If the need exists to use the MSG segment, it is highly recommended that the entity needing to use the MSG segment approach X12N with data maintenance to solve the business need without the use of the MSG segment.**

3. **Benefit Disclaimers are strongly discouraged. See section 1.3.10 Disclaimers Within the Transaction. Under no circumstances are more than one MSG segment to be used for a Benefit Disclaimer per individual response.**

Example: **MSG*Free form text is discouraged~**

STANDARD

MSG Message Text

Level: Detail

Position: 250

Loop: 2110

Requirement: Optional

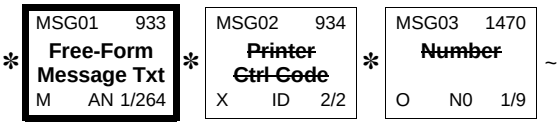
Max Use: 10

Purpose: To provide a free-form format that allows the transmission of text information

Syntax:

1. **C0302**
   If MSG03 is present, then MSG02 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**MSG01**	**933**	**Free-Form Message Text** Free-form message text *INDUSTRY:* ***Free Form Message Text***	**M AN 1/264**

NOT USED	MSG02	934	Printer Carriage Control Code	X	ID	2/2
NOT USED	MSG03	1470	Number	O	N0	1/9

IMPLEMENTATION

SUBSCRIBER ELIGIBILITY OR BENEFIT ADDITIONAL INFORMATION

Loop: **2115C — SUBSCRIBER ELIGIBILITY OR BENEFIT ADDITIONAL INFORMATION Repeat: 10**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Use this segment to begin the Subscriber Eligibility or Benefit Additional Information looping structure.**
2. **This segment has two purposes. Information that was received in III segments in Loop 2110C of the 270 Inquiry and was used in the determination of the eligibility or benefit response must be returned. If information was provided in III segments of Loop 2110C but was not used in the determination of the eligibiltiy or benefits it must not be returned. This segment can also be used to identify limitations in the benefits explained in the corresponding Loop 2110C, such as if benefits are limited to a type of facility or for a specific diagnosis code.**
3. **Use this segment to identify Diagnosis codes and/or Facility Type as they relate to the information provided in the EB segment.**
4. **Use the III segment only if an information source can support this high level functionality.**
5. **Use this segment only one time for the Principal Diagnosis Code and only one time for Facility Type Code.**

Example: **III*BK*486~**
III*ZZ*21~

STANDARD

III Information

Level: Detail

Position: 260

Loop: 2115 **Repeat:** >1

Requirement: Optional

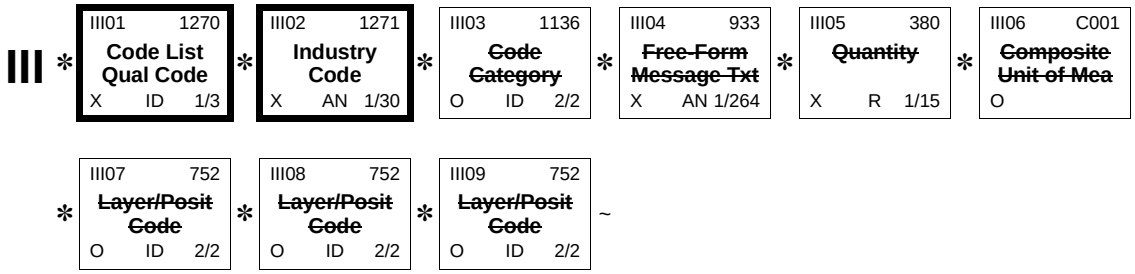
Max Use: 1

Purpose: To report information

Syntax:

1. **P0102**
   If either III01 or III02 is present, then the other is required.
2. **L030405**
   If III03 is present, then at least one of III04 or III05 are required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**III01**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **SYNTAX:** P0102 **Use this code to specify if the code that is following in the III02 is a Principal Diagnosis Code, a Diagnosis Code or a Facility Type Code.**	**X ID 1/3**

CODE	DEFINITION
BF	**Diagnosis**
	CODE SOURCE 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure
BK	**Principal Diagnosis**
	CODE SOURCE 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure
ZZ	**Mutually Defined** **Use this code for Facility Type Code.** **See Appendix C for Code Source 237, Place of Service from Health Care Financing Administration Claim Form.**

REQUIRED	**III02**	**1271**	**Industry Code** Code indicating a code from a specific industry code list SYNTAX: P0102	**X**	**AN**	**1/30**

If III01 is either BK or BF, use this element for diagnosis code from code source 131.

If III01 is ZZ, use this element for codes identifying a place of service from code source 237. As a courtesy, the codes are listed below, however, the code list is thought to be complete at the time of publication of this implementation guideline. Since this list is subject to change, only codes contained in the document available from code source 237 are to be supported in this transaction and take precedence over any and all codes listed here.

11 Office
12 Home
21 Inpatient Hospital
22 Outpatient Hospital
23 Emergency Room - Hospital
24 Ambulatory Surgical Center
25 Birthing Center
26 Military Treatment Facility
31 Skilled Nursing Facility
32 Nursing Facility
33 Custodial Care Facility
34 Hospice
41 Ambulance - Land
42 Ambulance - Air or Water
50 Federally Qualified Health Center
51 Inpatient Psychiatric Facility
52 Psychiatric Facility Partial Hospitalization
53 Community Mental Health Center
54 Intermediate Care Facility/Mentally Retarded
55 Residential Substance Abuse Treatment Facility
56 Psychiatric Residential Treatment Center
60 Mass Immunization Center
61 Comprehensive Inpatient Rehabilitation Facility
62 Comprehensive Outpatient Rehabilitation Facility
65 End-Stage Renal Disease Treatment Facility
71 State or Local Public Health Clinic
72 Rural Health Clinic
81 Independent Laboratory
99 Other Unlisted Facility

NOT USED	**III03**	**1136**	**Code Category**	**O**	**ID**	**2/2**
NOT USED	**III04**	**933**	**Free-Form Message Text**	**X**	**AN**	**1/264**
NOT USED	**III05**	**380**	**Quantity**	**X**	**R**	**1/15**
NOT USED	**III06**	**C001**	**COMPOSITE UNIT OF MEASURE**	**O**		
NOT USED	**III07**	**752**	**Surface/Layer/Position Code**	**O**	**ID**	**2/2**
NOT USED	**III08**	**752**	**Surface/Layer/Position Code**	**O**	**ID**	**2/2**
NOT USED	**III09**	**752**	**Surface/Layer/Position Code**	**O**	**ID**	**2/2**

IMPLEMENTATION

LOOP HEADER

Loop: **2110C — SUBSCRIBER ELIGIBILITY OR BENEFIT INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Use this segment to identify the beginning of the Subscriber Benefit Related Entity Name loop. Because both the subscriber's name loop and this loop begin with NM1 segments, the LS and LE segments are used to differentiate these two loops. Required if Loop 2120C is used.**

Example: **LS*2120~**

STANDARD

LS Loop Header

Level: Detail

Position: 330

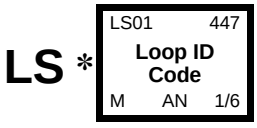
Loop: 2110

Requirement: Optional

Max Use: 1

Purpose: To indicate that the next segment begins a loop

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**LS01**	**447**	**Loop Identifier Code** The loop ID number given on the transaction set diagram is the value for this data element in segments LS and LE **This data element must have the value of "2120".**	**M AN 1/6**

IMPLEMENTATION

SUBSCRIBER BENEFIT RELATED ENTITY NAME

Loop: 2120C — SUBSCRIBER BENEFIT RELATED ENTITY NAME Repeat: 1

Usage: SITUATIONAL

Repeat: 1

Notes:
1. **Use this segment to identify an entity by name and/or identification number. This NM1 loop is used to identify a provider (such as the primary care provider), an individual, another payer, or another information source when applicable to the eligibility response.**

Example: NM1*P3*1*JONES*MARCUS*MD*SV*111223333~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 340

Loop: 2120 **Repeat:** 1

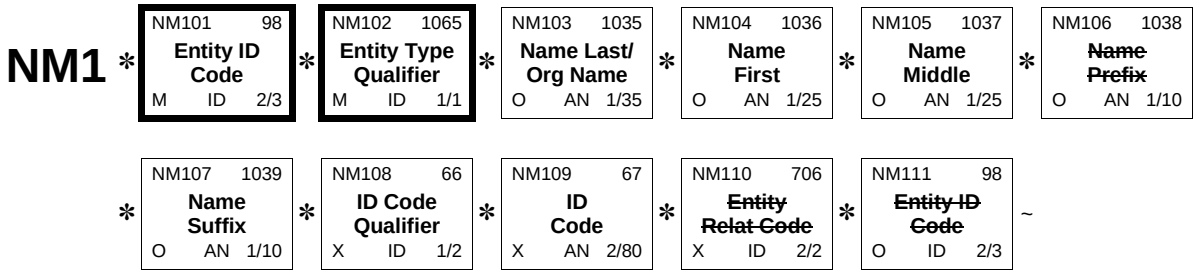
Requirement: Optional

Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

Syntax:
1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M ID 2/3**

CODE	DEFINITION
13	**Contracted Service Provider**

			1P	**Provider**			
			2B	**Third-Party Administrator**			
			36	**Employer**			
			73	**Other Physician**			
			FA	**Facility**			
			GP	**Gateway Provider**			
			IL	**Insured or Subscriber** **Use if identifying an insured or subscriber to a plan other than the information source (such as in a co-ordination of benefits situation).**			
			LR	**Legal Representative**			
			P3	**Primary Care Provider**			
			P4	**Prior Insurance Carrier**			
			P5	**Plan Sponsor**			
			PR	**Payer**			
			PRP	**Primary Payer**			
			SEP	**Secondary Payer**			
			TTP	**Tertiary Payer**			
			VN	**Vendor**			
			X3	**Utilization Management Organization**			
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103. **Use this code to indicate whether the entity is an individual person or an organization.**		**M**	**ID**	**1/1**
			CODE	**DEFINITION**			
			1	**Person**			
			2	**Non-Person Entity**			
SITUATIONAL	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name ***INDUSTRY:* *Benefit Related Entity Last or Organization Name*** **Use this name for the organization name if the entity type qualifier is a non-person entity. Otherwise, this will be the individual's last name.** **Use if available.**		**O**	**AN**	**1/35**

SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name	**O**	**AN**	**1/25**

INDUSTRY: ***Benefit Related Entity First Name***

Use this name only if available and NM102 is "1".

SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial	**O**	**AN**	**1/25**

INDUSTRY: ***Benefit Related Entity Middle Name***

Use this name only if available and NM102 is "1".

NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**AN**	**1/10**
SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name	**O**	**AN**	**1/10**

INDUSTRY: ***Benefit Related Entity Name Suffix***

Use name suffix only if available and NM102 is "1"; e.g., Sr., Jr., or III.

SITUATIONAL	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67)	**X**	**ID**	**1/2**

SYNTAX: P0809

If the entity being identified is a provider and the National Provider ID is mandated for use, code value "XX" must be used, otherwise, one of the other codes may be used. If the entity being identified is a payer and the HCFA National PlanID is mandated for use, code value "XV" must be used, otherwise, one of the other codes may be used. If the entity being identified is an individual, the "HIPAA Individual Identifier" must be used once this identifier has been adopted, otherwise, one of the other codes may be used.

Required when available.

CODE	DEFINITION
24	**Employer's Identification Number**
34	**Social Security Number** **The social security number may not be used for any Federally administered programs such as Medicare.**
46	**Electronic Transmitter Identification Number (ETIN)**
FA	**Facility Identification**
FI	**Federal Taxpayer's Identification Number**
MI	**Member Identification Number** **Use this code to identify the entity's Member Identification Number associated with a payer other than the information source in Loop 2100A. This code may only be used prior to the mandated use of code "ZZ".**
NI	**National Association of Insurance Commissioners (NAIC) Identification**

			PI **Payor Identification**			
			PP **Pharmacy Processor Number**			
			SV **Service Provider Number**			
			XV **Health Care Financing Administration National PlanID** ***Required if the National PlanID is mandated for use. Otherwise, one of the other listed codes may be used.***			
			CODE SOURCE **540:** Health Care Financing Administration National PlanID			
			XX **Health Care Financing Administration National Provider Identifier** ***Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.***			
			ZZ **Mutually Defined** **The value 'ZZ', when used in this data element shall be defined as "HIPAA Individual Identifier" once this identifier has been adopted. Under the Health Insurance Portability and Accountability Act of 1996, the Secretary of the Department of Health and Human Services must adopt a standard individual identifier for use in this transaction.**			
SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Benefit Related Entity Identifier*** SYNTAX: P0809 **Use this code for the reference number as qualified by the preceding data element (NM108).** **Required when available.**	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

SUBSCRIBER BENEFIT RELATED ENTITY ADDRESS

Loop: **2120C — SUBSCRIBER BENEFIT RELATED ENTITY NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Use this segment to identify address information for an entity.**
2. **Required when needed to further identify the entity or individual in loop 2120C NM1 and the information is available.**

Example: **N3*201 PARK AVENUE*SUITE 300~**

STANDARD

N3 Address Information

Level: Detail

Position: 360

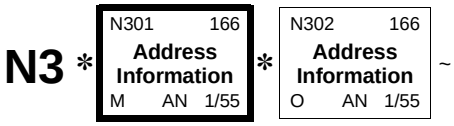
Loop: 2120

Requirement: Optional

Max Use: 1

Purpose: To specify the location of the named party

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N301**	**166**	**Address Information** Address information	**M**	**AN**	**1/55**
			INDUSTRY: ***Benefit Related Entity Address Line***			
			Use this information for the first line of the address information.			
SITUATIONAL	**N302**	**166**	**Address Information** Address information	**O**	**AN**	**1/55**
			INDUSTRY: ***Benefit Related Entity Address Line***			
			Use this information for the second line of the address information.			
			Required if a second address line exists.			

IMPLEMENTATION

SUBSCRIBER BENEFIT RELATED CITY/STATE/ZIP CODE

Loop: **2120C — SUBSCRIBER BENEFIT RELATED ENTITY NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Use this segment to identify the city, state and ZIP Code for an entity.**
2. **Required when needed to further identify the entity or individual in loop 2120C NM1 and the information is available.**

Example: **N4*NEW YORK*NY*10003~**

STANDARD

N4 Geographic Location

Level: Detail

Position: 370

Loop: 2120

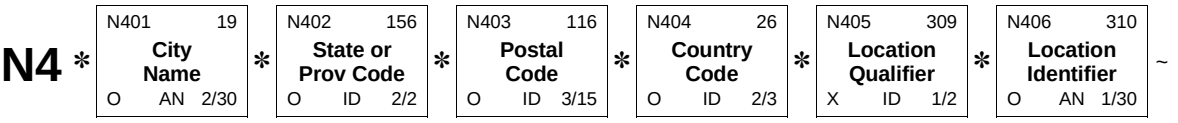
Requirement: Optional

Max Use: 1

Purpose: To specify the geographic place of the named party

Syntax:
1. **C0605**
   If N406 is present, then N405 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**N401**	**19**	**City Name** Free-form text for city name *INDUSTRY:* ***Benefit Related Entity City Name*** **COMMENT:** A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location. **Use this text for the city name of the entity's address.**	**O AN 2/30**

SITUATIONAL **N402** **156** **State or Province Code** **O** **ID** **2/2**
Code (Standard State/Province) as defined by appropriate government agency

INDUSTRY: ***Benefit Related Entity State Code***

COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada.

CODE SOURCE 22: States and Outlying Areas of the U.S.

Use this code for the state code of the entity's address.

SITUATIONAL **N403** **116** **Postal Code** **O** **ID** **3/15**
Code defining international postal zone code excluding punctuation and blanks (zip code for United States)

INDUSTRY: ***Benefit Related Entity Postal Zone or ZIP Code***

CODE SOURCE 51: ZIP Code

Use this code for the ZIP or Postal Code of the entity's address.

SITUATIONAL **N404** **26** **Country Code** **O** **ID** **2/3**
Code identifying the country

CODE SOURCE 5: Countries, Currencies and Funds

Use this code to specify the country of the entity's address, if other than the United States.

SITUATIONAL **N405** **309** **Location Qualifier** **X** **ID** **1/2**
Code identifying type of location

SYNTAX: C0605

Use only for CHAMPUS/TRICARE or CHAMPVA purposes.

CODE	DEFINITION
RJ	**Region** **Use this code only to communicate the Department of Defense Health Service Region in N406.**

SITUATIONAL **N406** **310** **Location Identifier** **O** **AN** **1/30**
Code which identifies a specific location

INDUSTRY: ***Department of Defense Health Service Region Code***

SYNTAX: C0605

Use only for CHAMPUS/TRICARE or CHAMPVA to communicate the Department of Defense Health Service Region for a Primary Care Provider.

CODE SOURCE DOD1: Military Health Systems Functional Area Manual - Data.

IMPLEMENTATION

SUBSCRIBER BENEFIT RELATED ENTITY CONTACT INFORMATION

Loop: **2120C — SUBSCRIBER BENEFIT RELATED ENTITY NAME**

Usage: **SITUATIONAL**

Repeat: **3**

Notes:

1. **Use this segment when needed to identify a contact name and/or communications number for the entity identified. This segment allows for three contact numbers to be listed. This segment is used when the information source wishes to provide a contact for the entity identified in loop 2120C NM1.**

   If telephone extension is sent, it should always be in the occurrence of the communications number following the actual phone number. See the example for an illustration.

2. **If this segment is used, at a minimum either PER02 must be used or PER03 and PER04 must be used. It is recommended that at least PER02, PER03 and PER04 are sent if this segment is used.**

3. **When the communication number represents a telephone number in the United States and other countries using the North American Dialing Plan (for voice, data, fax, etc.), the communication number should always include the area code and phone number using the format AAABBBCCCC. Where AAA is the area code, BBB is the telephone number prefix, and CCCC is the telephone number (e.g. (534)224-2525 would be represented as 5342242525). The extension, when applicable, should be included in the communication number immediately after the telephone number.**

4. **By definition of the standard, if PER03 is used, PER04 is required.**

Example: **PER*IC*BILLING DEPT*TE*2128763654*EX*2104*FX*2128769304~**

STANDARD

PER Administrative Communications Contact

Level: Detail

Position: 380

Loop: 2120

Requirement: Optional

Max Use: 3

Purpose: To identify a person or office to whom administrative communications should be directed

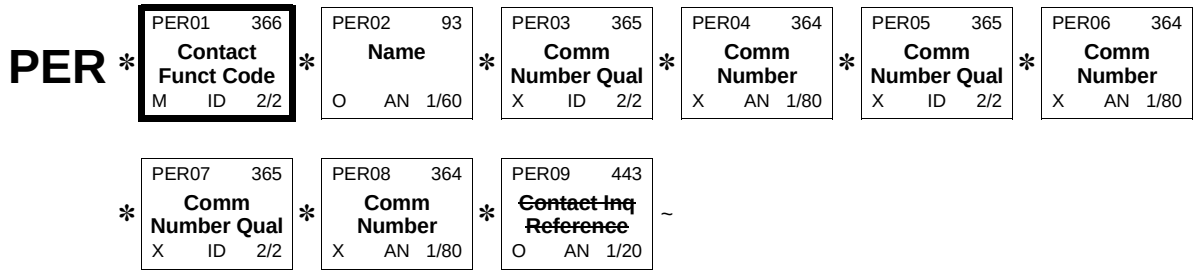
Syntax:

1. **P0304**
   If either PER03 or PER04 is present, then the other is required.

2. **P0506**
   If either PER05 or PER06 is present, then the other is required.

3. **P0708**
   If either PER07 or PER08 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PER01**	**366**	**Contact Function Code** Code identifying the major duty or responsibility of the person or group named **Use this code to specify the type of person or group to which the contact number applies.**	**M ID 2/2**
SITUATIONAL	**PER02**	**93**	**Name** Free-form name *INDUSTRY:* ***Benefit Related Entity Contact Name*** **Use this name for the individual's name or group's name to use when contacting the individual or organization.** **Use this data element when the name of the individual to contact is not already defined or is different than the name within the prior name segment (e.g. N1 or NM1).**	**O AN 1/60**
SITUATIONAL	**PER03**	**365**	**Communication Number Qualifier** Code identifying the type of communication number SYNTAX: P0304 **Use this code to specify what type of communication number is following.**	**X ID 2/2**

CODE	DEFINITION
IC	**Information Contact**

CODE	DEFINITION
ED	**Electronic Data Interchange Access Number**
EM	**Electronic Mail**
FX	**Facsimile**
TE	**Telephone**
WP	**Work Phone Number**

SITUATIONAL **PER04** **364** **Communication Number** **X** **AN** **1/80**
Complete communications number including country or area code when applicable

INDUSTRY: ***Benefit Related Entity Communication Number***

SYNTAX: P0304

Required when PER02 is not present or when a contact number is to be sent in addition to the contact name. Use this number for the communication number as qualified by the preceding data element.

The format for US domestic phone numbers is:
AAABBBCCCC
AAA = Area Code
BBBCCCC = Local Number

SITUATIONAL **PER05** **365** **Communication Number Qualifier** **X** **ID** **2/2**
Code identifying the type of communication number

SYNTAX: P0506

Use this code to specify what type of communication number is following.

CODE	DEFINITION
ED	**Electronic Data Interchange Access Number**
EM	**Electronic Mail**
EX	**Telephone Extension**
FX	**Facsimile**
TE	**Telephone**
WP	**Work Phone Number**

SITUATIONAL **PER06** **364** **Communication Number** **X** **AN** **1/80**
Complete communications number including country or area code when applicable

INDUSTRY: ***Benefit Related Entity Communication Number***

SYNTAX: P0506

Required when an additional contact number is to be sent. Use this number for the communication number as qualified by the preceding data element.

The format for US domestic phone numbers is:
AAABBBCCCC
AAA = Area Code
BBBCCCC = Local Number

SITUATIONAL **PER07** **365** **Communication Number Qualifier** **X** **ID** **2/2**
Code identifying the type of communication number

SYNTAX: P0708

Use this code to specify what type of communication number is following.

CODE	DEFINITION
ED	**Electronic Data Interchange Access Number**

			EM	**Electronic Mail**			
			EX	**Telephone Extension**			
			FX	**Facsimile**			
			TE	**Telephone**			
			WP	**Work Phone Number**			
SITUATIONAL	**PER08**	**364**	**Communication Number** Complete communications number including country or area code when applicable *INDUSTRY:* ***Benefit Related Entity Communication Number*** SYNTAX: P0708 **Required when an additional contact number is to be sent. Use this number for the communication number as qualified by the preceding data element.** **The format for US domestic phone numbers is:** **AAABBBCCCC** **AAA = Area Code** **BBBCCCC = Local Number**	**X**	**AN**	**1/80**
NOT USED	**PER09**	**443**	**Contact Inquiry Reference**	**O**	**AN**	**1/20**

IMPLEMENTATION

SUBSCRIBER BENEFIT RELATED PROVIDER INFORMATION

Loop: **2120C — SUBSCRIBER BENEFIT RELATED ENTITY NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Use this segment when needed to either identify a specific provider or associate a specialty type related to the service identified in the 2110C loop.**
2. **If identifying a specific provider, use this segment to convey specific information about a provider's role in the eligibility/benefit being inquired about when the provider is not the information receiver. For example, if the information receiver is a hospital and a referring provider must be identified, this is the segment where the referring provider would be identified.**
3. **If identifying a specific provider, this segment contains reference identification numbers, all of which may be used up until the time the National Provider Identifier (NPI) is mandated for use. After the NPI is mandated, only the code for National Provider Identifier may be used.**
4. **If identifying a type of specialty associated with the services identified in loop 2110C, use code ZZ in PRV02 and the appropriate code in PRV03.**
5. **PRV02 qualifies PRV03.**

Example: **PRV*PE*EI*9991234567~**
PRV*PE*ZZ*203BA0504N~

STANDARD

PRV Provider Information

Level: Detail

Position: 390

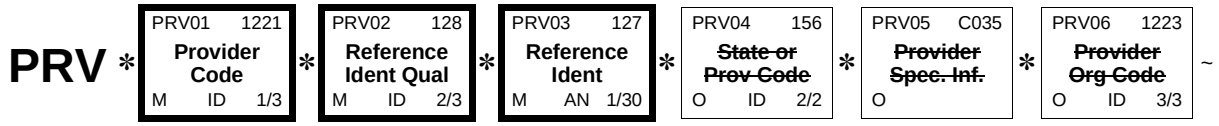
Loop: 2120

Requirement: Optional

Max Use: 1

Purpose: To specify the identifying characteristics of a provider

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	PRV01	1221	**Provider Code** Code indentifying the type of provider	M	ID	1/3

CODE	DEFINITION
AT	Attending
BI	Billing
CO	Consulting
CV	Covering
H	Hospital
HH	Home Health Care
LA	Laboratory
OT	Other Physician
P1	Pharmacist
P2	Pharmacy
PC	Primary Care Physician
PE	Performing
R	Rural Health Clinic
RF	Referring
SK	Skilled Nursing Facility

REQUIRED	PRV02	128	**Reference Identification Qualifier** Code qualifying the Reference Identification	M	ID	2/3

If the National Provider ID is mandated for use, code value "HPI" must be used, otherwise one of the other code values may be used.

ZZ is used to indicate the "Health Care Provider Taxonomy" code list (provider specialty code) which is available on the Washington Publishing Company web site: http://www.wpc-edi.com. This taxonomy is maintained by the Blue Cross Blue Shield Association and ASC X12N TG2 WG15.

CODE	DEFINITION
9K	**Servicer** **Use this code for the identification number assigned by the information source to be used by the information receiver in health care transactions.**
D3	**National Association of Boards of Pharmacy Number** CODE SOURCE **307:** National Association of Boards of Pharmacy Number

			EI	**Employer's Identification Number**			
			HPI	**Health Care Financing Administration National Provider Identifier** **Required value when identifying a specific provider when the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.** CODE SOURCE **537:** Health Care Financing Administration National Provider Identifier			
			SY	**Social Security Number** **The social security number may not be used for any Federally administered programs such as Medicare.**			
			TJ	**Federal Taxpayer's Identification Number**			
			ZZ	**Mutually Defined** **Health Care Provider Taxonomy Code list.**			
REQUIRED	**PRV03**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Provider Identifier*** **Use this reference number as qualified by the preceding data element (PRV02).**		**M**	**AN**	**1/30**
NOT USED	**PRV04**	**156**	**State or Province Code**		**O**	**ID**	**2/2**
NOT USED	**PRV05**	**C035**	**PROVIDER SPECIALTY INFORMATION**		**O**		
NOT USED	**PRV06**	**1223**	**Provider Organization Code**		**O**	**ID**	**3/3**

IMPLEMENTATION

LOOP TRAILER

Loop: **2110C — SUBSCRIBER ELIGIBILITY OR BENEFIT INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Use this segment to identify the end of the Subscriber Benefit Related Entity Name loop. Because both the subscriber's name loop and this loop begin with NM1 segments, the LS and LE segments are used to differentiate these two loops. Required if Loop 2120C is used.**

Example: **LE*2120~**

STANDARD

LE Loop Trailer

Level: Detail

Position: 400

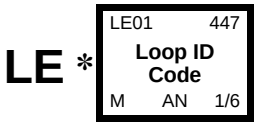
Loop: 2110

Requirement: Optional

Max Use: 1

Purpose: To indicate that the loop immediately preceding this segment is complete

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**LE01**	**447**	**Loop Identifier Code** The loop ID number given on the transaction set diagram is the value for this data element in segments LS and LE **This data element must have the value of "2120".**	**M AN 1/6**

IMPLEMENTATION

DEPENDENT LEVEL

Loop: **2000D — DEPENDENT LEVEL Repeat: >1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Use this segment to identify the hierarchical or entity level of information being conveyed. The HL structure allows for the efficient nesting of related occurrences of information. The developers' intent is to clearly identify the relationship of the patient to the subscriber and the subscriber to the provider.**

   Additionally, multiple subscribers and/or dependents (i.e., the patient) can be grouped together under the same provider or the information for multiple providers or information receivers can be grouped together for the same payer or information source.

2. **An example of the overall structure of the transaction set when used in batch mode is:**

   Information Source Loop 2000A
   Information Receiver Loop 2000B
   Subscriber Loop 2000C
   Dependent Loop 2000D
   Eligibility or Benefit Information
   Dependent Loop 2000D
   Eligibility or Benefit Information
   Subscriber Loop 2000C
   Eligibility or Benefit Information

Example: **HL*4*3*23*0~**

STANDARD

HL Hierarchical Level

Level: Detail

Position: 010

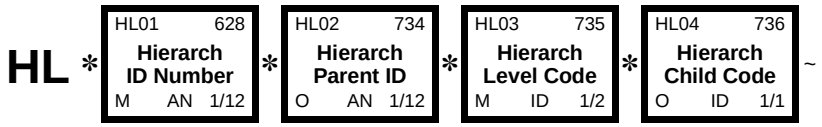
Loop: 2000 **Repeat:** >1

Requirement: Mandatory

Max Use: 1

Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure COMMENT: HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction. **Use the sequentially assigned positive number to identify each specific occurrence of an HL segment within a transaction set. It should begin with the number one and be incremented by one for each successive occurrence of the HL segment within that specific transaction set (ST through SE).** **An example of the use of the HL segment and this data element is:** **HL*1**20*1~** **NM1*PR*2*ABC INSURANCE COMPANY*****PI*842610001~** **HL*2*1*21*1~** **NM1*1P*1*JONES*MARCUS***MD*SV*0202034~** **HL*3*2*22*1~** **NM1*IL*1*SMITH*ROBERT*B***MI*11122333301~** **HL*4*3*23*0~** **NM1*03*1*SMITH*MARY*LOU~** **Eligibility/Benefit Data** **HL*5*2*22*0~** **NM1*IL*1*BROWN*JOHN*E***MI*22211333301~** **Eligibility/Benefit Data**	**M AN 1/12**
REQUIRED	**HL02**	**734**	**Hierarchical Parent ID Number** Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to COMMENT: HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate. **Use this ID number to identify the specific hierarchical level to which this level is subordinate.**	**O AN 1/12**
REQUIRED	**HL03**	**735**	**Hierarchical Level Code** Code defining the characteristic of a level in a hierarchical structure COMMENT: HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information. **All data that follows an HL segment is associated with the entity identified by the level code; this association continues until the next occurrence of an HL segment.**	**M ID 1/2**

CODE	DEFINITION
23	**Dependent** **Use the dependent level to identify an individual(s) who may be a dependent of the subscriber/insured. This entity may or may not be the actual patient.**

REQUIRED **HL04** **736** **Hierarchical Child Code** **O ID 1/1**

Code indicating if there are hierarchical child data segments subordinate to the level being described

COMMENT: HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

Use this code to indicate whether there are additional hierarchical levels subordinate to the current hierarchical level.

Because of the hierarchical structure, and because no subordinate HL levels exist, the code value in the HL04 at the Loop 2000D level should be "0" (zero).

CODE	DEFINITION
0	**No Subordinate HL Segment in This Hierarchical Structure.**

IMPLEMENTATION

DEPENDENT TRACE NUMBER

Loop: 2000D — DEPENDENT LEVEL

Usage: SITUATIONAL

Repeat: 3

Notes:

1. Use this segment to convey a unique trace or reference number. See Section 1.3.6 Information Linkage for additional information.

2. An information source may receive up to two TRN segments in each loop 2000D of a 270 transaction and must return each of them in loop 2000D of the 271 transaction with a value of “2" in TRN01.

3. An information source may add one TRN segment to loop 2000D with a value of “1" in TRN01 and must identify themselves in TRN03.

4. If this transaction passes through a clearinghouse, the clearinghouse will receive from the information source the information receiver’s TRN segment and the clearinghouse’s TRN segment with a value of “2" in TRN01. Since the ultimate destination of the transaction is the information receiver, if the clearinghouse intends on passing their TRN segment to the information receiver, the clearinghouse must change the value in TRN01 to ”1" of their TRN segment. This must be done since the trace number in the clearinghouse’s TRN segment is not actually a referenced transaction trace number to the information receiver.

Example:
TRN*2*98175-012547*9877281234*RADIOLOGY~
TRN*2*109834652831*9XYZCLEARH*REALTIME~
TRN*1*209991094361*9ABCINSURE~

The above example represents how an information source would respond. The first TRN segment was initiated by the information receiver. The second TRN segment was initiated by the clearinghouse. The third TRN segment was initiated by the information source.

Example:
TRN*2*98175-012547*9877281234*RADIOLOGY~
TRN*1*109834652831*9XYZCLEARH*REALTIME~
TRN*1*209991094361*9ABCINSURE~

The above example represents how a clearinghouse would respond to the same set of TRN segments if the clearinghouse intends to pass their TRN segment on to the information receiver. If the clearinghouse does not intend to pass their TRN segment on to the information receiver, only the first and third TRN segments in the example would be sent.

STANDARD

TRN Trace

Level: Detail

Position: 020

Loop: 2000

Requirement: Optional

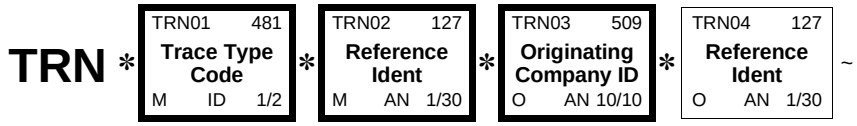
Max Use: 9

Purpose: To uniquely identify a transaction to an application

Set Notes:

1. If the Eligibility, Coverage or Benefit Inquiry Transaction Set (270) includes a TRN segment, then the Eligibility, Coverage or Benefit Information Transaction Set (271) must return the trace number identified in the TRN segment.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**TRN01**	**481**	**Trace Type Code** Code identifying which transaction is being referenced	**M ID 1/2**

CODE	DEFINITION
1	**Current Transaction Trace Numbers** **The term "Current Transaction Trace Numbers" refers to trace or reference numbers assigned by the creator of the 271 transaction (the information source).** **If a clearinghouse has assigned a TRN segment and intends on returning their TRN segment in the 271 response to the information receiver, they must convert the value in TRN01 to "1" (since it will be returned by the information source as a "2").**
2	**Referenced Transaction Trace Numbers** **The term "Referenced Transaction Trace Numbers" refers to trace or reference numbers originally sent in the 270 transaction and now returned in the 271.**

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**TRN02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**M AN 1/30**

INDUSTRY: ***Trace Number***

SEMANTIC: TRN02 provides unique identification for the transaction.

REQUIRED **TRN03** **509** **Originating Company Identifier** **O AN 10/10**

A unique identifier designating the company initiating the funds transfer instructions. The first character is one-digit ANSI identification code designation (ICD) followed by the nine-digit identification number which may be an IRS employer identification number (EIN), data universal numbering system (DUNS), or a user assigned number; the ICD for an EIN is 1, DUNS is 3, user assigned number is 9

INDUSTRY: ***Trace Assigning Entity Identifier***

SEMANTIC: TRN03 identifies an organization.

If TRN01 is "2", this is the value received in the original 270 transaction.

If TRN01 is "1", use this information to identify the organization that assigned this trace number.

The first position must be either a "1" if an EIN is used, a "3" if a DUNS is used or a "9" if a user assigned identifier is used.

SITUATIONAL **TRN04** **127** **Reference Identification** **O AN 1/30**

Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

INDUSTRY: ***Trace Assigning Entity Additional Identifier***

SEMANTIC: TRN04 identifies a further subdivision within the organization.

If TRN01 is "2", this is the value received in the original 270 transaction.

If TRN01 is "1", use this information if necessary to further identify a specific component, such as a specific division or group of the entity identified in the previous data element (TRN03).

IMPLEMENTATION

DEPENDENT NAME

Loop: **2100D — DEPENDENT NAME** **Repeat:** **1**

Usage: **REQUIRED**

Repeat: **1**

Notes: **1. Use this segment to identify an entity by name and/or identification number. This NM1 loop is used to identify the dependent of an insured or subscriber.**

Example: **NM1*03*1*SMITH*JOHN*L**JR*MI*444115555~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 030

Loop: 2100 **Repeat:** >1

Requirement: Optional

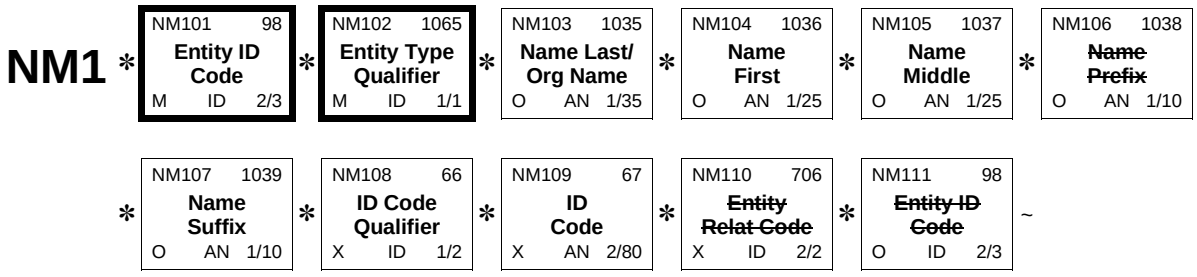
Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

Syntax: **1. P0809**
If either NM108 or NM109 is present, then the other is required.

2. C1110
If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M ID 2/3**

CODE	DEFINITION
03	**Dependent**

REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity	**M**	**ID**	**1/1**

SEMANTIC: NM102 qualifies NM103.

CODE	DEFINITION
1	**Person**

SITUATIONAL	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name	**O**	**AN**	**1/35**

INDUSTRY: ***Dependent Last Name***

Use this name for the dependent's last name.

Required unless a rejection response is generated and this element was not valued in the request.

SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name	**O**	**AN**	**1/25**

INDUSTRY: ***Dependent First Name***

Use this name for the dependent's first name.

Required unless a rejection response is generated and this element was not valued in the request.

SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial	**O**	**AN**	**1/25**

INDUSTRY: ***Dependent Middle Name***

Use this name for the dependent's middle name or initial.

Required if this is availalble from the Information Source's database unless a rejection response is generated and this element was not valued in the request.

NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**AN**	**1/10**
SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name	**O**	**AN**	**1/10**

INDUSTRY: ***Dependent Name Suffix***

Use this for the suffix to an individual's name; e.g., Sr., Jr., or III.

Use if available.

SITUATIONAL	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67)	**X**	**ID**	**1/2**

SYNTAX: P0809

Use this element to qualify the identification number submitted in NM109. This is the primary number that the information source associates with the dependent.

Prior to the mandated use of the HIPAA Unique Patient Identifier, the Member Identification Number for the dependent will be returned if the information source has assigned a unique identifier for the dependent. Subsequent 270 requests should contain this Member Identification Number and the dependent would then be submitted as the subscriber.

Required when available.

CODE	DEFINITION
MI	**Member Identification Number** **This code may only be used prior to the mandated use of code "ZZ". This is the unique number the payer or information source uses to identify the insured (e.g., Health Insurance Claim Number, Medicaid Recipient ID Number, HMO Member ID, etc.).**
ZZ	**Mutually Defined** **The value 'ZZ', when used in this data element shall be defined as "HIPAA Individual Identifier" once this identifier has been adopted. Under the Health Insurance Portability and Accountability Act of 1996, the Secretary of the Department of Health and Human Services must adopt a standard individual identifier for use in this transaction.**

SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code	**X**	**AN**	**2/80**

INDUSTRY: ***Dependent Primary Identifier***

SYNTAX: P0809

Use this code for the reference number as qualified by the preceding data element (NM108).

Required when available.

NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

DEPENDENT ADDITIONAL IDENTIFICATION

Loop: **2100D — DEPENDENT NAME**

Usage: **SITUATIONAL**

Repeat: **9**

Notes:

1. **Use this segment to supply an identification number other than or in addition to the Member Identification Number. The type of reference number is determined by the qualifier in REF01.**

2. **Required if the Information Source requires additional identifiers necessary to identify the Subscriber for other transactions such as claims, authorizations, etc.**

3. **Health Insurance Claim (HIC) Number or Medicaid Recipient Identification Numbers are to be provided in the NM1 segment as a Member Identification Number when it is the primary number an information source knows a member by (such as for Medicare or Medicaid). Do not use this segment for the Health Insurance Claim (HIC) Number or Medicaid Recipient Identification Number unless they are different from the Member Identification Number provided in the NM1 segment.**

4. **If the 270 request contained a REF segment with a Patient Account Number in Loop 2100D/REF02 with REF01 equal EJ, then it must be returned in the 271 transaction using this segment.**

Example: **REF*18*660415~**

Example: **REF*49*03~**

STANDARD

REF Reference Identification

Level: Detail

Position: 040

Loop: 2100

Requirement: Optional

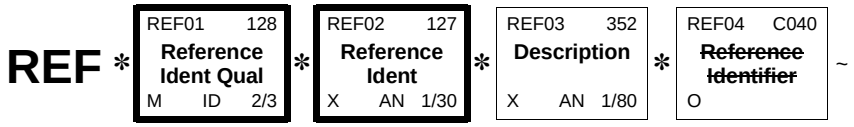
Max Use: 9

Purpose: To specify identifying information

Syntax:

1. **R0203**
   At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	**Reference Identification Qualifier** Code qualifying the Reference Identification	M ID 2/3

Use this code to specify or qualify the type of reference number that is following in REF02, REF03, or both.

CODE	DEFINITION
18	Plan Number
1L	Group or Policy Number Use this code only if it cannot be determined if the number is a Group Number or a Policy number. Use codes "IG" or "6P" when they can be determined.
1W	Member Identification Number Use only if Loop 2100D NM108 contains ZZ, and is prior to the mandated use of the HIPAA Unique Patient Identifier.
49	Family Unit Number This is the suffix to the Dependent's Member Identification Number which allows the information source to use one identification number as the base number for each family member. The suffix identifies the individual family member. Only the suffix is to be entered here. The Member Identification Number is to be entered in Loop 2100C NM109 or REF02. If the complete Member Identification Number with the suffix is entered in Loop 2100D NM109 or REF02, the suffix should not be entered here.
6P	Group Number
EA	Medical Record Identification Number
EJ	Patient Account Number
F6	Health Insurance Claim (HIC) Number See segment note 2.
GH	Identification Card Serial Number Use this code when the Identification Card has a number in addition to the Member Identification Number or Identity Card Number. The Identification Card Serial Number uniquely identifies the card when multiple cards have been or will be issued to a member (e.g., on a monthly basis, replacement cards). This is particularly prevalent in the Medicaid environment.

			HJ	**Identity Card Number** **Use this code when the Identity Card Number is different than the Member Identification Number. This is particularly prevalent in the Medicaid environment.**			
			IF	**Issue Number**			
			IG	**Insurance Policy Number**			
			M7	**Medical Assistance Category**			
			N6	**Plan Network Identification Number**			
			NQ	**Medicaid Recipient Identification Number** **See segment note 2.**			
			Q4	**Prior Identifier Number** **This code is to be used when a corrected or new identification number is returned in NM109, the originally submitted identification number is to be returned in REF02. To be used in conjunction with code "001" in INS03 and code "25" in INS04.**			
			SY	**Social Security Number** **The social security number may not be used for any Federally administered programs such as Medicare.**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Dependent Supplemental Identifier*** SYNTAX: R0203 **Use this information for the reference number as qualified by the preceding data element (REF01).**		**X**	**AN**	**1/30**
SITUATIONAL	**REF03**	**352**	**Description** A free-form description to clarify the related data elements and their content *INDUSTRY:* ***Plan Sponsor Name*** SYNTAX: R0203 **Use if available.**		**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**		**O**		

IMPLEMENTATION

DEPENDENT ADDRESS

Loop: **2100D — DEPENDENT NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Use this segment to identify address information for a dependent.**
2. **Use of this segment is required if the transaction is not rejected and address information is available from the information source's database.**
3. **Do not return address information from the 270 request.**

Example: **N3*15197 BROADWAY AVENUE*APT 215~**

STANDARD

N3 Address Information

Level: Detail

Position: 060

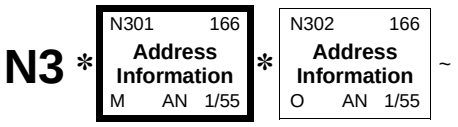
Loop: 2100

Requirement: Optional

Max Use: 1

Purpose: To specify the location of the named party

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N301**	**166**	**Address Information** Address information *INDUSTRY:* ***Dependent Address Line*** **Use this information for the first line of the address information.**	**M**	**AN**	**1/55**
SITUATIONAL	**N302**	**166**	**Address Information** Address information *INDUSTRY:* ***Dependent Address Line*** **Use this information for the second line of the address information.** **Required if a second address line exists.**	**O**	**AN**	**1/55**

IMPLEMENTATION

DEPENDENT CITY/STATE/ZIP CODE

Loop: **2100D — DEPENDENT NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Use this segment to identify the city, state and ZIP Code for a dependent.**
2. **Use of this segment is required if the transaction is not rejected and address information is available from the information source's database.**
3. **Do not return address information from the 270 request.**

Example: **N4*NEW YORK*NY*10003~**

STANDARD

N4 Geographic Location

Level: Detail

Position: 070

Loop: 2100

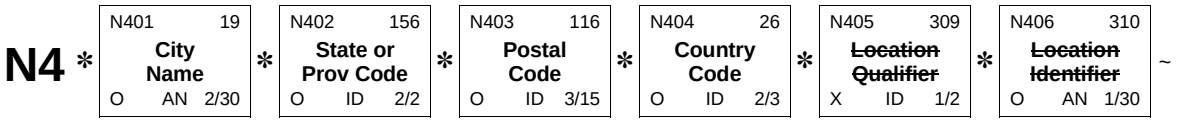
Requirement: Optional

Max Use: 1

Purpose: To specify the geographic place of the named party

Syntax:
1. **C0605**
   If N406 is present, then N405 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**N401**	**19**	**City Name** Free-form text for city name *INDUSTRY:* ***Dependent City Name*** **COMMENT:** A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location. **Use this text for the city name of the dependent's address.**	**O AN 2/30**

SITUATIONAL	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency	**O**	**ID**	**2/2**
			INDUSTRY: ***Dependent State Code***			
			COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada.			
			CODE SOURCE 22: States and Outlying Areas of the U.S.			
			Use this code for the state code of the dependent's address.			
SITUATIONAL	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States)	**O**	**ID**	**3/15**
			INDUSTRY: ***Dependent Postal Zone or ZIP Code***			
			CODE SOURCE 51: ZIP Code			
			Use this code for the ZIP or Postal Code of the dependent's address.			
SITUATIONAL	**N404**	**26**	**Country Code** Code identifying the country	**O**	**ID**	**2/3**
			CODE SOURCE 5: Countries, Currencies and Funds			
			Required if address is outside the United States.			
NOT USED	**N405**	**309**	**Location Qualifier**	**X**	**ID**	**1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O**	**AN**	**1/30**

IMPLEMENTATION

DEPENDENT CONTACT INFORMATION

Loop: **2100D — DEPENDENT NAME**

Usage: **SITUATIONAL**

Repeat: **3**

Notes:

1. **Use this segment when needed to identify a contact name and/or communications number for the entity identified. This segment allows for three contact numbers to be listed. This segment is used when the information source wishes to provide a contact for the entity identified in loop 2100D NM1.**

   If telephone extension is sent, it should always be in the occurrence of the communications number following the actual phone number. See the example for an illustration.

2. **If this segment is used, at a minimum either PER02 must be used or PER03 and PER04 must be used. It is recommended that at least PER02, PER03 and PER04 are sent if this segment is used.**

3. **When the communication number represents a telephone number in the United States and other countries using the North American Dialing Plan (for voice, data, fax, etc.), the communication number should always include the area code and phone number using the format AAABBBCCCC. Where AAA is the area code, BBB is the telephone number prefix, and CCCC is the telephone number (e.g. (534)224-2525 would be represented as 5342242525). The extension, when applicable, should be included in the communication number immediately after the telephone number.**

4. **By definition of the standard, if PER03 is used, PER04 is required.**

Example: **PER*IC**HP*2128779765*WP*2127838736*EX*763~**

STANDARD

PER Administrative Communications Contact

Level: Detail

Position: 080

Loop: 2100

Requirement: Optional

Max Use: 3

Purpose: To identify a person or office to whom administrative communications should be directed

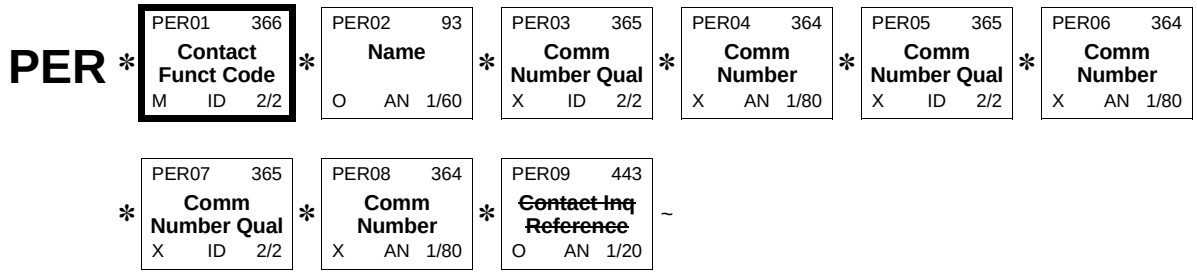
Syntax:

1. **P0304**
   If either PER03 or PER04 is present, then the other is required.

2. **P0506**
   If either PER05 or PER06 is present, then the other is required.

3. P0708
If either PER07 or PER08 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PER01**	**366**	**Contact Function Code** Code identifying the major duty or responsibility of the person or group named **Use this code to specify the type of person or group to which the contact number applies.** CODE / DEFINITION **IC** — **Information Contact**	**M ID 2/2**
SITUATIONAL	**PER02**	**93**	**Name** Free-form name *INDUSTRY:* ***Dependent Contact Name*** **Use this name for the individual's name or group's name to use when contacting the individual or organization.** **Use this data element when the name of the individual to contact is not already defined or is different than the name within the prior name segment (e.g. N1 or NM1).**	**O AN 1/60**
SITUATIONAL	**PER03**	**365**	**Communication Number Qualifier** Code identifying the type of communication number SYNTAX: P0304 **Use this code to specify what type of communication number is following.** CODE / DEFINITION **HP** — **Home Phone Number** **TE** — **Telephone** **WP** — **Work Phone Number**	**X ID 2/2**

SITUATIONAL **PER04** **364** **Communication Number** **X** **AN** **1/80**
Complete communications number including country or area code when applicable

INDUSTRY: ***Dependent Contact Number***

SYNTAX: P0304

Required when PER02 is not present or when a contact number is to be sent in addition to the contact name. Use this number for the communication number as qualified by the preceding data element.

The format for US domestic phone numbers is:
AAABBBCCCC
AAA = Area Code
BBBCCCC = Local Number

SITUATIONAL **PER05** **365** **Communication Number Qualifier** **X** **ID** **2/2**
Code identifying the type of communication number

SYNTAX: P0506

Use this code to specify what type of communication number is following.

CODE	DEFINITION
EX	**Telephone Extension**
HP	**Home Phone Number**
TE	**Telephone**
WP	**Work Phone Number**

SITUATIONAL **PER06** **364** **Communication Number** **X** **AN** **1/80**
Complete communications number including country or area code when applicable

INDUSTRY: ***Dependent Contact Number***

SYNTAX: P0506

Required when an additional contact number is to be sent. Use this number for the communication number as qualified by the preceding data element.

The format for US domestic phone numbers is:
AAABBBCCCC
AAA = Area Code
BBBCCCC = Local Number

SITUATIONAL **PER07** **365** **Communication Number Qualifier** **X** **ID** **2/2**
Code identifying the type of communication number

SYNTAX: P0708

Use this code to specify what type of communication number is following.

CODE	DEFINITION
EX	**Telephone Extension**
HP	**Home Phone Number**
TE	**Telephone**

			WP Work Phone Number			
SITUATIONAL	**PER08**	**364**	**Communication Number** Complete communications number including country or area code when applicable *INDUSTRY:* ***Dependent Contact Number*** SYNTAX: P0708 **Required when an additional contact number is to be sent. Use this number for the communication number as qualified by the preceding data element.** **The format for US domestic phone numbers is:** **AAABBBCCCC** **AAA = Area Code** **BBBCCCC = Local Number**	**X**	**AN**	**1/80**
NOT USED	**PER09**	**443**	**Contact Inquiry Reference**	**O**	**AN**	**1/20**

IMPLEMENTATION

DEPENDENT REQUEST VALIDATION

Loop: **2100D — DEPENDENT NAME**

Usage: **SITUATIONAL**

Repeat: **9**

Notes:

1. **Use this segment when a request could not be processed at a system or application level and to indicate what action the originator of the request transaction should take.**

2. **Use this segment to indicate problems in processing the transaction specifically related to the data contained in the original 270 transaction's dependent name loop (Loop 2100D).**

Example: **AAA*N**72*C~**

STANDARD

AAA Request Validation

Level: Detail

Position: 085

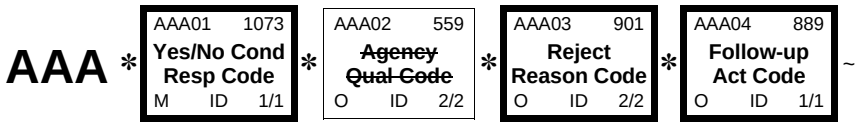
Loop: 2100

Requirement: Optional

Max Use: 9

Purpose: To specify the validity of the request and indicate follow-up action authorized

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**AAA01**	**1073**	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response *INDUSTRY:* ***Valid Request Indicator*** **SEMANTIC:** AAA01 designates whether the request is valid or invalid. Code "Y" indicates that the code is valid; code "N" indicates that the code is invalid.	**M**	**ID**	**1/1**
			CODE / **DEFINITION** **N** — **No** **Y** — **Yes**			
NOT USED	**AAA02**	**559**	**Agency Qualifier Code**	**O**	**ID**	**2/2**

REQUIRED **AAA03** **901** **Reject Reason Code** **O** **ID** **2/2**
Code assigned by issuer to identify reason for rejection

Use this code for the reason why the transaction was unable to be processed successfully. This may indicate problems with the system, the application, or the data content.

Use codes "43", "45", "47", "48", or "51" only in response to information that is in or should be in the PRV segment in the Dependent Name loop (2100D).

CODE	DEFINITION
15	Required application data missing
42	Unable to Respond at Current Time Use this code in a batch environment where an information source returns all requests from the 270 in the 271 and identifies "Unable to Respond at Current Time" for each individual request (subscriber or dependent) within the transaction that they were unable to process for reasons other than data content (such as their system is down or timed out in generating a response). Use only codes "R", "S", or "Y" for AAA04.
43	Invalid/Missing Provider Identification
45	Invalid/Missing Provider Specialty
47	Invalid/Missing Provider State
48	Invalid/Missing Referring Provider Identification Number
49	Provider is Not Primary Care Physician
51	Provider Not on File
52	Service Dates Not Within Provider Plan Enrollment
56	Inappropriate Date
57	Invalid/Missing Date(s) of Service
58	Invalid/Missing Date-of-Birth
60	Date of Birth Follows Date(s) of Service
61	Date of Death Precedes Date(s) of Service
62	Date of Service Not Within Allowable Inquiry Period
63	Date of Service in Future
64	Invalid/Missing Patient ID
65	Invalid/Missing Patient Name
66	Invalid/Missing Patient Gender Code
67	Patient Not Found

			68	**Duplicate Patient ID Number**			
			71	**Patient Birth Date Does Not Match That for the Patient on the Database**			
REQUIRED	**AAA04**	**889**	**Follow-up Action Code** Code identifying follow-up actions allowed		**O**	**ID**	**1/1**

Use this code to instruct the recipient of the 271 about what action needs to be taken, if any, based on the validity code and the reject reason code (if applicable).

CODE	DEFINITION
C	**Please Correct and Resubmit**
N	**Resubmission Not Allowed**
R	**Resubmission Allowed** **Use only when AAA03 is "42".**
S	**Do Not Resubmit; Inquiry Initiated to a Third Party**
W	**Please Wait 30 Days and Resubmit**
X	**Please Wait 10 Days and Resubmit**
Y	**Do Not Resubmit; We Will Hold Your Request and Respond Again Shortly** **Use only when AAA03 is "42".**

IMPLEMENTATION

DEPENDENT DEMOGRAPHIC INFORMATION

Loop: **2100D — DEPENDENT NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Use this segment to convey the birth date or gender demographic information for the dependent.**
2. **Required if this is availalble from the Information Source's database unless a rejection response is generated and this element was not valued in the request.**

Example: **DMG*D8*19750616*M~**

STANDARD

DMG Demographic Information

Level: Detail

Position: 100

Loop: 2100

Requirement: Optional

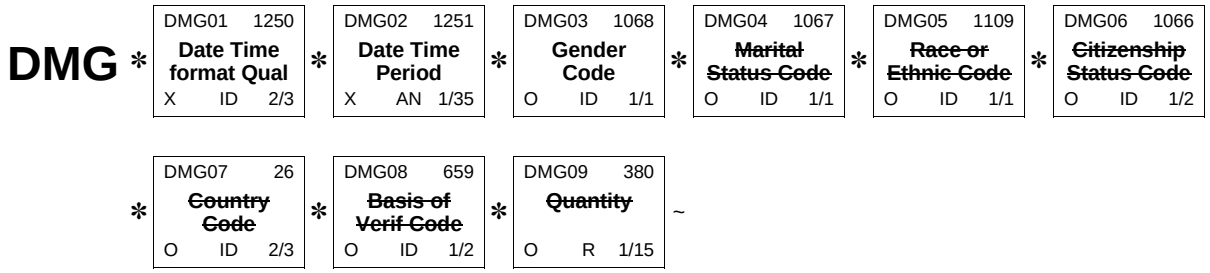
Max Use: 1

Purpose: To supply demographic information

Syntax:

1. **P0102**
   If either DMG01 or DMG02 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	DMG01	1250	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format SYNTAX: P0102 **Use this code to indicate the format of the date of birth that follows in DMG02.** CODE: **D8** — DEFINITION: **Date Expressed in Format CCYYMMDD**	X ID 2/3
SITUATIONAL	DMG02	1251	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: ***Dependent Birth Date*** SYNTAX: P0102 SEMANTIC: DMG02 is the date of birth. **Use this date for the date of birth of the individual.** **Required if this is availalble from the Information Source's database unless a rejection response is generated and this element was not valued in the request.**	X AN 1/35
SITUATIONAL	DMG03	1068	**Gender Code** Code indicating the sex of the individual INDUSTRY: ***Dependent Gender Code*** **Required if this is availalble from the Information Source's database unless a rejection response is generated and this element was not valued in the request.** CODE / DEFINITION: **F** — **Female** **M** — **Male** **U** — **Unknown**	O ID 1/1
NOT USED	DMG04	1067	**Marital Status Code**	O ID 1/1
NOT USED	DMG05	1109	**Race or Ethnicity Code**	O ID 1/1
NOT USED	DMG06	1066	**Citizenship Status Code**	O ID 1/2
NOT USED	DMG07	26	**Country Code**	O ID 2/3
NOT USED	DMG08	659	**Basis of Verification Code**	O ID 1/2
NOT USED	DMG09	380	**Quantity**	O R 1/15

IMPLEMENTATION

DEPENDENT RELATIONSHIP

Loop: **2100D — DEPENDENT NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Use this segment if necessary to convey insurance related information about the individual identified.**

2. **This segment may also be used to identify that the information source has changed some of the identifying elements for the dependent that the information receiver submitted in the original 270 transaction.**

3. **Different types of health plans identify patients in different manners depending upon how their eligibility is structured. However, two approaches predominate.**

   The first approach is to assign each individual member of the family (and plan) a unique ID number. This number can be used to identify and access that individual's information independent of whether he or she is a child, spouse, or the actual subscriber to the plan. In this approach, the patient can be identified at the subscriber or insured hierarchical level because a unique ID number exists to access eligibility information for this individual. The relationship of this individual to the actual subscriber or contract holder would be one of spouse, child, self, etc.

   The second approach is to assign the actual subscriber or contract holder a unique ID number that is entered into the eligibility system. Any related spouse, children, or dependents are identified through the subscriber's ID and have no unique identification number of their own. In this approach, the subscriber would be identified at the Loop 2100C subscriber or insured level, and the actual patient (spouse, child, etc.) would be identified at the Loop 2100D dependent level under the subscriber.

Example: **INS*N*19*******F********3~**

STANDARD

INS Insured Benefit

Level: Detail

Position: 110

Loop: 2100

Requirement: Optional

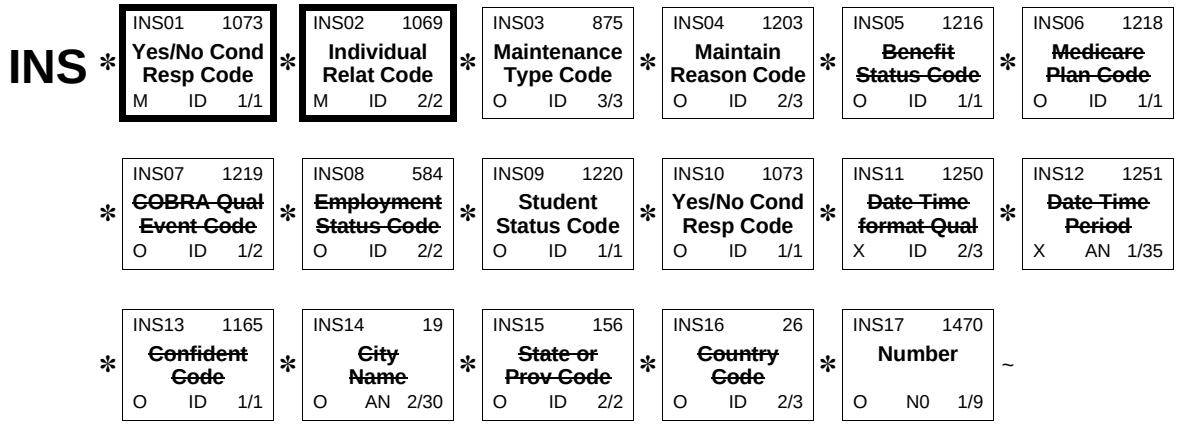
Max Use: 1

Purpose: To provide benefit information on insured entities

Syntax:

1. **P1112**
   If either INS11 or INS12 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**INS01**	**1073**	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response *INDUSTRY:* ***Insured Indicator*** **SEMANTIC:** INS01 indicates status of the insured. A "Y" value indicates the insured is a subscriber: an "N" value indicates the insured is a dependent.	**M ID 1/1**
			CODE **DEFINITION** **N** **No**	
REQUIRED	**INS02**	**1069**	**Individual Relationship Code** Code indicating the relationship between two individuals or entities	**M ID 2/2**
			CODE **DEFINITION** **01** **Spouse** **19** **Child** **21** **Unknown** **Use this code only if relationship information is not available and there is a need to use data elements INS03, INS04, INS09, INS10 or INS17.** **34** **Other Adult**	
SITUATIONAL	**INS03**	**875**	**Maintenance Type Code** Code identifying the specific type of item maintenance **Use this element (and code "25" in INS04) if any of the identifying elements for the subscriber have been changed from those submitted in the 270.**	**O ID 3/3**
			CODE **DEFINITION** **001** **Change**	

SITUATIONAL	**INS04**	**1203**	**Maintenance Reason Code** Code identifying the reason for the maintenance change	**O**	**ID**	**2/3**

Use this element (and code "001" in INS03) if any of the identifying elements for the subscriber have been changed from those submitted in the 270.

CODE	DEFINITION
25	**Change in Indentifying Data Elements** **Use this code to indicate that a change has been made to the primary elements that identify a specific person. Such elements are first name, last name, date of birth, and identification numbers.**

NOT USED	**INS05**	**1216**	**Benefit Status Code**	**O**	**ID**	**1/1**
NOT USED	**INS06**	**1218**	**Medicare Plan Code**	**O**	**ID**	**1/1**
NOT USED	**INS07**	**1219**	**Consolidated Omnibus Budget Reconciliation Act (COBRA) Qualifying**	**O**	**ID**	**1/2**
NOT USED	**INS08**	**584**	**Employment Status Code**	**O**	**ID**	**2/2**
SITUATIONAL	**INS09**	**1220**	**Student Status Code** Code indicating the student status of the patient if 19 years of age or older, not handicapped and not the insured	**O**	**ID**	**1/1**

Use if available.

CODE	DEFINITION
F	**Full-time**
N	**Not a Student**
P	**Part-time**

SITUATIONAL	**INS10**	**1073**	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response	**O**	**ID**	**1/1**

INDUSTRY: ***Handicap Indicator***

SEMANTIC: INS10 is the handicapped status indicator. A "Y" value indicates an individual is handicapped; an "N" value indicates an individual is not handicapped.

Use if available.

CODE	DEFINITION
N	**No**
Y	**Yes**

NOT USED	**INS11**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**INS12**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**INS13**	**1165**	**Confidentiality Code**	**O**	**ID**	**1/1**
NOT USED	**INS14**	**19**	**City Name**	**O**	**AN**	**2/30**
NOT USED	**INS15**	**156**	**State or Province Code**	**O**	**ID**	**2/2**
NOT USED	**INS16**	**26**	**Country Code**	**O**	**ID**	**2/3**

SITUATIONAL	**INS17**	**1470**	**Number** A generic number	**O**	**N0**	**1/9**

INDUSTRY: ***Birth Sequence Number***

SEMANTIC: INS17 is the number assigned to each family member born with the same birth date. This number identifies birth sequence for multiple births allowing proper tracking and response of benefits for each dependent (i.e., twins, triplets, etc.).

Use to indicate the birth order in the event of multiple birth's in association with the birth date supplied in DMG02.

IMPLEMENTATION

DEPENDENT DATE

Loop: 2100D — DEPENDENT NAME

Usage: SITUATIONAL

Repeat: 9

Notes:

1. **Use this segment to convey any relevant dates. The dates represented may be in the past, the current date, or a future date. The dates may also be a single date or a span of dates. Which date(s) to use is determined by the format qualifier in DTP02.**

2. **When using codes "307" (Eligibility), "356" (Eligibility Begin), "357" (Eligibility End), "435" (Admission) or "472" (Service) at this level, it is implied that these dates apply to all of the Eligibility or Benefit Information (EB) loops that follow.**

Example: DTP*346*D8*19950818~

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 120

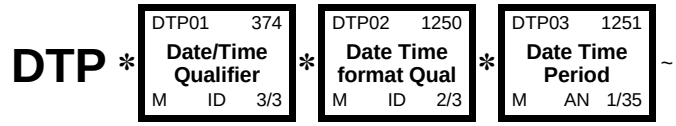
Loop: 2100

Requirement: Optional

Max Use: 9

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	DTP01	374	**Date/Time Qualifier** Code specifying type of date or time, or both date and time	M ID 3/3

INDUSTRY: ***Date Time Qualifier***

CODE	DEFINITION
102	Issue
152	Effective Date of Change
291	Plan
307	Eligibility

			318	**Added**			
			340	**Consolidated Omnibus Budget Reconciliation Act (COBRA) Begin**			
			341	**Consolidated Omnibus Budget Reconciliation Act (COBRA) End**			
			342	**Premium Paid to Date Begin**			
			343	**Premium Paid to Date End**			
			346	**Plan Begin**			
			347	**Plan End**			
			382	**Enrollment**			
			435	**Admission**			
			442	**Date of Death**			
			458	**Certification**			
			472	**Service**			
			539	**Policy Effective**			
			540	**Policy Expiration**			
			636	**Date of Last Update**			
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier**		**M**	**ID**	**2/3**
			Code indicating the date format, time format, or date and time format				
			SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03.				
			Use this code to specify the format of the date(s)/time(s) that follow in the next data element.				
			CODE	**DEFINITION**			
			D8	**Date Expressed in Format CCYYMMDD**			
			RD8	**Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD**			
REQUIRED	**DTP03**	**1251**	**Date Time Period**		**M**	**AN**	**1/35**
			Expression of a date, a time, or range of dates, times or dates and times				
			Use this date for the date(s) as qualified by the preceding data elements.				

IMPLEMENTATION

DEPENDENT ELIGIBILITY OR BENEFIT INFORMATION

Loop: 2110D — DEPENDENT ELIGIBILITY OR BENEFIT INFORMATION
Repeat: >1

Usage: SITUATIONAL

Repeat: 1

Notes:

1. Use this segment to begin the eligibility/benefit information looping structure. The EB segment is used to convey the specific eligibility or benefit information for the entity identified.

2. This segment is required if the dependent is the person whose eligibility or benefits are being described and the transaction is not rejected (see Section 1.3.9) or if the transaction needs to be rejected in this loop.

3. A limit to the number of repeats of EB loops has not been established. In a batch environment there is no practical reason to limit the number of EB loop repeats. In a real time environment, consideration should be given to how many EB loops are generated given the amount of time it takes to format the response and the amount of time it will take to transmit that response. Since these limitations will vary by information source, it would be completely arbitrary for the developers to set a limit. It is not the intent of the developers to limit the amount of information that is returned in a response, rather to alert information sources to consider the potential delays if the response contains too much information to be formatted and transmitted in real time.

4. The minimum data for a HIPAA compliant response for a person that has been located in the information source's system must indicate either, 1- Active Coverage or 6 - Inactive in EB01 and, 30 - Health Benefit Plan Coverage in EB03. Information sources are not limited to the minimum HIPAA compliant response and are highly encouraged to create as elaborate a response their systems allow. See section 1.3.7 HIPAA Compliant Use of the 270/271 Transaction Set for additional information.

Example: EB*1*FAM*96*GP~

Example: EB*B**98***27*10**VS*1~

Example: EB*C*IND****23*200~

Example: EB*C*FAM****23*600~

Example: EB*A**A6*****.50~

Example: EB*L~

STANDARD

EB Eligibility or Benefit Information

Level: Detail

Position: 130

Loop: 2110 **Repeat:** >1

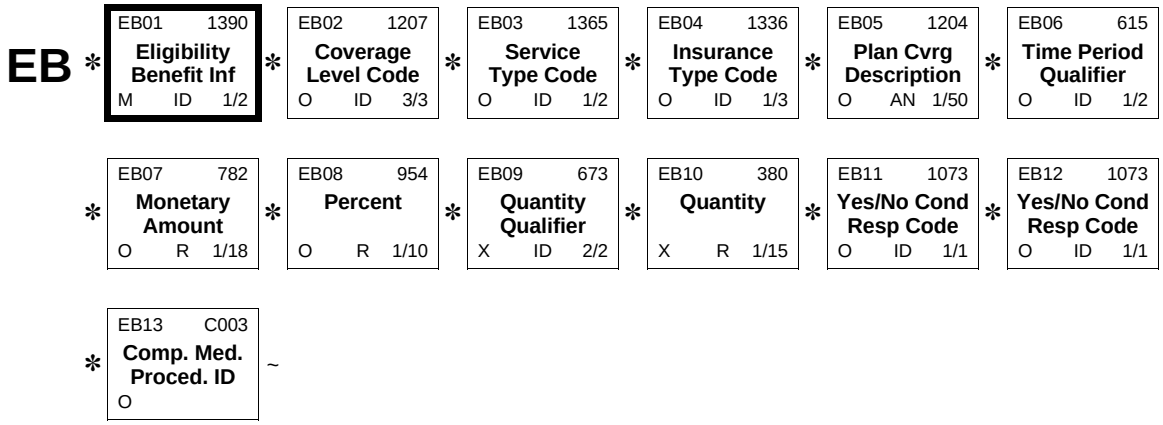
Requirement: Optional

Max Use: 1

Purpose: To supply eligibility or benefit information

Syntax: **1. P0910**
If either EB09 or EB10 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**EB01**	**1390**	**Eligibility or Benefit Information** Code identifying eligibility or benefit information SEMANTIC: EB01 qualifies EB06 through EB10. **Use this code to identify the eligibility or benefit information. This may be the eligibility status of the individual or the benefit related category that is being further described in the following data elements. This data element also qualifies the data in elements EB06 through EB10.**	**M ID 1/2**

CODE	DEFINITION
1	**Active Coverage**
2	**Active - Full Risk Capitation**
3	**Active - Services Capitated**
4	**Active - Services Capitated to Primary Care Physician**
5	**Active - Pending Investigation**

6	Inactive
7	Inactive - Pending Eligibility Update
8	Inactive - Pending Investigation
A	Co-Insurance
B	Co-Payment
C	Deductible
CB	Coverage Basis
D	Benefit Description
E	Exclusions
F	Limitations
G	Out of Pocket (Stop Loss)
H	Unlimited
I	Non-Covered
J	Cost Containment
K	Reserve
L	Primary Care Provider
M	Pre-existing Condition
MC	Managed Care Coordinator
N	Services Restricted to Following Provider
O	Not Deemed a Medical Necessity
P	Benefit Disclaimer Not recommended. See section 1.3.10 Disclaimers Within the Transaction.
Q	Second Surgical Opinion Required
R	Other or Additional Payor
S	Prior Year(s) History
T	Card(s) Reported Lost/Stolen
U	Contact Following Entity for Eligibility or Benefit Information
V	Cannot Process
W	Other Source of Data
X	Health Care Facility
Y	Spend Down

SITUATIONAL **EB02** **1207** **Coverage Level Code** **O** **ID** **3/3**
Code indicating the level of coverage being provided for this insured

INDUSTRY: ***Benefit Coverage Level Code***

Use this code to identify the level of coverage of benefits. It identifies the types and number of entities that are covered by the insurance plan.

Use if available.

CODE	DEFINITION
CHD	Children Only
DEP	Dependents Only
ECH	Employee and Children
ESP	Employee and Spouse
FAM	Family
IND	Individual
SPC	Spouse and Children
SPO	Spouse Only

SITUATIONAL **EB03** **1365** **Service Type Code** **O** **ID** **1/2**
Code identifying the classification of service

If a service type code is sent by an information receiver that is not supported by the information source, the information source must respond with at least a service type code of 30 - Health Benefit Plan Coverage. See EB segment notes and section 1.3.7 HIPAA Compliant Use of the 270/271 Transaction Set for additional information. Information receivers need to be made aware that receipt of a 271 response with a Service Type Code of 30 indicates that the information source may not be able to process an explicit request and the response does not indicate coverage of a specific benefit if one was sent in the 270 request.

If a very specific type or category of service for which eligibility or benefits can be described, use one of the codes from the full list.

CODE	DEFINITION
1	Medical Care
2	Surgical
3	Consultation
4	Diagnostic X-Ray
5	Diagnostic Lab
6	Radiation Therapy
7	Anesthesia
8	Surgical Assistance

9	Other Medical
10	Blood Charges
11	Used Durable Medical Equipment
12	Durable Medical Equipment Purchase
13	Ambulatory Service Center Facility
14	Renal Supplies in the Home
15	Alternate Method Dialysis
16	Chronic Renal Disease (CRD) Equipment
17	Pre-Admission Testing
18	Durable Medical Equipment Rental
19	Pneumonia Vaccine
20	Second Surgical Opinion
21	Third Surgical Opinion
22	Social Work
23	Diagnostic Dental
24	Periodontics
25	Restorative
26	Endodontics
27	Maxillofacial Prosthetics
28	Adjunctive Dental Services
30	Health Benefit Plan Coverage Use this code if only a single category of benefits can be supported.
32	Plan Waiting Period
33	Chiropractic
34	Chiropractic Office Visits
35	Dental Care
36	Dental Crowns
37	Dental Accident
38	Orthodontics
39	Prosthodontics
40	Oral Surgery
41	Routine (Preventive) Dental

42	Home Health Care
43	Home Health Prescriptions
44	Home Health Visits
45	Hospice
46	Respite Care
47	Hospital
48	Hospital - Inpatient
49	Hospital - Room and Board
50	Hospital - Outpatient
51	Hospital - Emergency Accident
52	Hospital - Emergency Medical
53	Hospital - Ambulatory Surgical
54	Long Term Care
55	Major Medical
56	Medically Related Transportation
57	Air Transportation
58	Cabulance
59	Licensed Ambulance
60	General Benefits
61	In-vitro Fertilization
62	MRI/CAT Scan
63	Donor Procedures
64	Acupuncture
65	Newborn Care
66	Pathology
67	Smoking Cessation
68	Well Baby Care
69	Maternity
70	Transplants
71	Audiology Exam
72	Inhalation Therapy

73	Diagnostic Medical
74	Private Duty Nursing
75	Prosthetic Device
76	Dialysis
77	Otological Exam
78	Chemotherapy
79	Allergy Testing
80	Immunizations
81	Routine Physical
82	Family Planning
83	Infertility
84	Abortion
85	AIDS
86	Emergency Services
87	Cancer
88	Pharmacy
89	Free Standing Prescription Drug
90	Mail Order Prescription Drug
91	Brand Name Prescription Drug
92	Generic Prescription Drug
93	Podiatry
94	Podiatry - Office Visits
95	Podiatry - Nursing Home Visits
96	Professional (Physician)
97	Anesthesiologist
98	Professional (Physician) Visit - Office
99	Professional (Physician) Visit - Inpatient
A0	Professional (Physician) Visit - Outpatient
A1	Professional (Physician) Visit - Nursing Home
A2	Professional (Physician) Visit - Skilled Nursing Facility
A3	Professional (Physician) Visit - Home

A4	Psychiatric
A5	Psychiatric - Room and Board
A6	Psychotherapy
A7	Psychiatric - Inpatient
A8	Psychiatric - Outpatient
A9	Rehabilitation
AA	Rehabilitation - Room and Board
AB	Rehabilitation - Inpatient
AC	Rehabilitation - Outpatient
AD	Occupational Therapy
AE	Physical Medicine
AF	Speech Therapy
AG	Skilled Nursing Care
AH	Skilled Nursing Care - Room and Board
AI	Substance Abuse
AJ	Alcoholism
AK	Drug Addiction
AL	Vision (Optometry)
AM	Frames
AN	Routine Exam
AO	Lenses
AQ	Nonmedically Necessary Physical
AR	Experimental Drug Therapy
BA	Independent Medical Evaluation
BB	Partial Hospitalization (Psychiatric)
BC	Day Care (Psychiatric)
BD	Cognitive Therapy
BE	Massage Therapy
BF	Pulmonary Rehabilitation
BG	Cardiac Rehabilitation
BH	Pediatric
BI	Nursery

			BJ	**Skin**
			BK	**Orthopedic**
			BL	**Cardiac**
			BM	**Lymphatic**
			BN	**Gastrointestinal**
			BP	**Endocrine**
			BQ	**Neurology**
			BR	**Eye**
			BS	**Invasive Procedures**

SITUATIONAL **EB04** **1336** **Insurance Type Code** **O** **ID** **1/3**
Code identifying the type of insurance policy within a specific insurance program

Use if available.

CODE	DEFINITION
12	**Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan**
13	**Medicare Secondary End-Stage Renal Disease Beneficiary in the 12 month coordination period with an employer's group health plan**
14	**Medicare Secondary, No-fault Insurance including Auto is Primary**
15	**Medicare Secondary Worker's Compensation**
16	**Medicare Secondary Public Health Service (PHS)or Other Federal Agency**
41	**Medicare Secondary Black Lung**
42	**Medicare Secondary Veteran's Administration**
43	**Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)**
47	**Medicare Secondary, Other Liability Insurance is Primary**
AP	**Auto Insurance Policy**
C1	**Commercial**
CO	**Consolidated Omnibus Budget Reconciliation Act (COBRA)**
CP	**Medicare Conditionally Primary**
D	**Disability**
DB	**Disability Benefits**

EP	Exclusive Provider Organization
FF	Family or Friends
GP	Group Policy
HM	Health Maintenance Organization (HMO)
HN	Health Maintenance Organization (HMO) - Medicare Risk
HS	Special Low Income Medicare Beneficiary
IN	Indemnity
IP	Individual Policy
LC	Long Term Care
LD	Long Term Policy
LI	Life Insurance
LT	Litigation
MA	Medicare Part A
MB	Medicare Part B
MC	Medicaid
MH	Medigap Part A
MI	Medigap Part B
MP	Medicare Primary
OT	Other
PE	Property Insurance - Personal
PL	Personal
PP	Personal Payment (Cash - No Insurance)
PR	Preferred Provider Organization (PPO)
PS	Point of Service (POS)
QM	Qualified Medicare Beneficiary
RP	Property Insurance - Real
SP	Supplemental Policy
TF	Tax Equity Fiscal Responsibility Act (TEFRA)
WC	Workers Compensation
WU	Wrap Up Policy

SITUATIONAL	**EB05**	**1204**	**Plan Coverage Description** A description or number that identifies the plan or coverage	**O**	**AN**	**1/50**

Use this free-form text area to convey the specific product name for an insurance plan.

Use if available.

SITUATIONAL	**EB06**	**615**	**Time Period Qualifier** Code defining periods	**O**	**ID**	**1/2**

Use this code for the time period category for the benefits being described when needed to qualify benefit availability.

CODE	DEFINITION
6	**Hour**
7	**Day**
13	**24 Hours**
21	**Years**
22	**Service Year**
23	**Calendar Year**
24	**Year to Date**
25	**Contract**
26	**Episode**
27	**Visit**
28	**Outlier**
29	**Remaining**
30	**Exceeded**
31	**Not Exceeded**
32	**Lifetime**
33	**Lifetime Remaining**
34	**Month**
35	**Week**
36	**Admisson**

SITUATIONAL	**EB07**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***Benefit Amount***

Use this monetary amount as qualified by EB01.

Use if elegibility or benefit must be qualified by a monetary amount; e.g., deductible, co-payment.

SITUATIONAL	**EB08**	**954**	**Percent** Percentage expressed as a decimal	**O**	**R**	**1/10**

INDUSTRY: ***Benefit Percent***

Use this percentage rate as qualified by EB01.

Use if elegibility or benefit must be qualified by a percentage; e.g., co-insurance.

SITUATIONAL	**EB09**	**673**	**Quantity Qualifier** Code specifying the type of quantity	**X**	**ID**	**2/2**

SYNTAX: P0910

Use this code to identify the type of units that are being conveyed in the following data element (EB10).

CODE	DEFINITION
99	**Quantity Used**
CA	**Covered - Actual**
CE	**Covered - Estimated**
DB	**Deductible Blood Units**
DY	**Days**
HS	**Hours**
LA	**Life-time Reserve - Actual**
LE	**Life-time Reserve - Estimated**
MN	**Month**
P6	**Number of Services or Procedures**
QA	**Quantity Approved**
S7	**Age, High Value** **Use this code when a benefit is based on a maximum age for the patient.**
S8	**Age, Low Value** **Use this code when a benefit is based on a minimum age for the patient.**
VS	**Visits**
YY	**Years**

SITUATIONAL	**EB10**	**380**	**Quantity** Numeric value of quantity	**X**	**R**	**1/15**

INDUSTRY: ***Benefit Quantity***

SYNTAX: P0910

Use this number for the quantity value as qualified by the preceding data element (EB09).

SITUATIONAL **EB11** **1073** **Yes/No Condition or Response Code** **O** **ID** **1/1**
Code indicating a Yes or No condition or response

INDUSTRY: ***Authorization or Certification Indicator***

SEMANTIC: EB11 is the authorization or certification indicator. A "Y" value indicates that an authorization or certification is required per plan provisions. An "N" value indicates that an authorization or certification is not required per plan provisions. A "U" value indicates it is unknown whether the plan provisions require an authorization or certification.

Use if it is necessary to indicate if authorization or certification is required.

CODE	DEFINITION
N	No
U	Unknown
Y	Yes

SITUATIONAL **EB12** **1073** **Yes/No Condition or Response Code** **O** **ID** **1/1**
Code indicating a Yes or No condition or response

INDUSTRY: ***In Plan Network Indicator***

SEMANTIC: EB12 is the plan network indicator. A "Y" value indicates the benefits identified are considered In-Plan-Network. An "N" value indicates that the benefits identified are considered Out-Of-Plan-Network. A "U" value indicates it is unknown whether the benefits identified are part of the Plan Network.

Use if it is necessary to indicate if benefits are considered In or Out of Plan-Network or not.

CODE	DEFINITION
N	No
U	Unknown
Y	Yes

SITUATIONAL **EB13** **C003** **COMPOSITE MEDICAL PROCEDURE IDENTIFIER** **O**
To identify a medical procedure by its standardized codes and applicable modifiers

Use this composite data element only if an information source can support this high level of functionality. The EB13 allows for a very specific response to a very specific inquiry, such as based on a diagnosis or a procedure code. This element is only recommended when responding to an inquiry that contained related EQ02 data.

REQUIRED **EB13 - 1** **235** **Product/Service ID Qualifier** **M** **ID** **2/2**
Code identifying the type/source of the descriptive number used in Product/Service ID (234)

INDUSTRY: ***Product or Service ID Qualifier***

Use this code to identify the external code list of the following procedure/service code.

CODE	DEFINITION
AD	**American Dental Association Codes**
	CODE SOURCE 135: American Dental Association Codes
CJ	**Current Procedural Terminology (CPT) Codes**
	CODE SOURCE 133: Current Procedural Terminology (CPT) Codes
HC	**Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes**
	CODE SOURCE 130: Health Care Financing Administration Common Procedural Coding System
ID	**International Classification of Diseases Clinical Modification (ICD-9-CM) - Procedure**
	CODE SOURCE 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure
ND	**National Drug Code (NDC)**
	CODE SOURCE 134: National Drug Code
ZZ	**Mutually Defined** **NOT ADVISED** **Use this code only for local codes or interim uses until an appropriate new code is approved.**

REQUIRED **EB13 - 2** **234** **Product/Service ID** **M AN 1/48**
Identifying number for a product or service

INDUSTRY: ***Procedure Code***

Use this ID number for the product/service code as qualified by the preceding data element.

SITUATIONAL **EB13 - 3** **1339** **Procedure Modifier** **O AN 2/2**
This identifies special circumstances related to the performance of the service, as defined by trading partners

Use this modifier for the procedure code identified in EB13-2 if modifiers are needed to further specify the service.

SITUATIONAL **EB13 - 4** **1339** **Procedure Modifier** **O AN 2/2**
This identifies special circumstances related to the performance of the service, as defined by trading partners

Use this modifier for the procedure code identified in EB13-2 if modifiers are needed to further specify the service.

SITUATIONAL **EB13 - 5** **1339** **Procedure Modifier** **O AN 2/2**
This identifies special circumstances related to the performance of the service, as defined by trading partners

Use this modifier for the procedure code identified in EB13-2 if modifiers are needed to further specify the service.

SITUATIONAL **EB13 - 6** **1339** **Procedure Modifier** **O AN 2/2**
This identifies special circumstances related to the performance of the service, as defined by trading partners

Use this modifier for the procedure code identified in EB13-2 if modifiers are needed to further specify the service.

NOT USED **EB13 - 7** **352** **Description** **O AN 1/80**

IMPLEMENTATION

HEALTH CARE SERVICES DELIVERY

Loop: **2110D — DEPENDENT ELIGIBILITY OR BENEFIT INFORMATION**

Usage: **SITUATIONAL**

Repeat: **9**

Notes:
1. **Use this segment only when benefits identified in either EB03 or EB13 have a specific delivery or usage pattern associated with the benefit.**

Example: **HSD*VS*30***22~**
Thirty visits per service year

Example: **HSD*VS*12*WK*3*34*1~**
Twelve visits, three visits per week, for 1 month.

STANDARD

HSD Health Care Services Delivery

Level: Detail

Position: 135

Loop: 2110

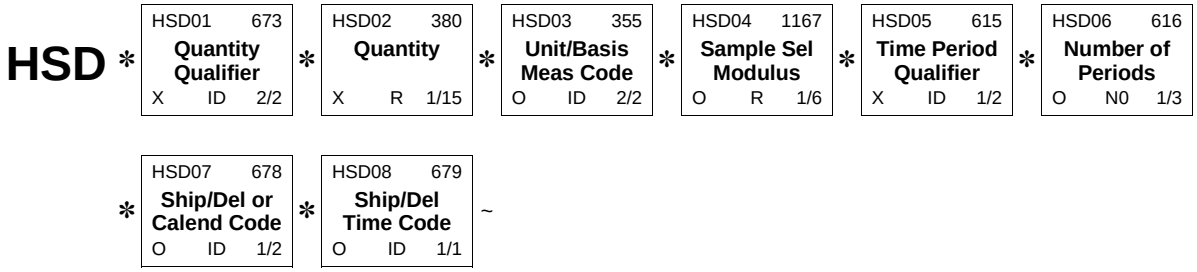
Requirement: Optional

Max Use: 9

Purpose: To specify the delivery pattern of health care services

Syntax:
1. **P0102**
   If either HSD01 or HSD02 is present, then the other is required.
2. **C0605**
   If HSD06 is present, then HSD05 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**HSD01**	**673**	**Quantity Qualifier** Code specifying the type of quantity SYNTAX: P0102 **Required if identifying type and quantity of benefits.** **Required if HSD02 is used.**	**X ID 2/2**
			CODE / DEFINITION **DY** Days **FL** Units **HS** Hours **MN** Month **VS** Visits	
SITUATIONAL	**HSD02**	**380**	**Quantity** Numeric value of quantity *INDUSTRY:* ***Benefit Quantity*** SYNTAX: P0102 **Required if identifying type and quantity of benefits.** **Required if HSD01 is used.**	**X R 1/15**
SITUATIONAL	**HSD03**	**355**	**Unit or Basis for Measurement Code** Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken **Used if needed to provide further information about the number and frequency of benefits.**	**O ID 2/2**
			CODE / DEFINITION **DA** Days **MO** Months **VS** Visit **WK** Week **YR** Years	
SITUATIONAL	**HSD04**	**1167**	**Sample Selection Modulus** To specify the sampling frequency in terms of a modulus of the Unit of Measure, e.g., every fifth bag, every 1.5 minutes **Used if needed to provide further information about the number and frequency of benefits.**	**O R 1/6**

SITUATIONAL **HSD05** **615** **Time Period Qualifier** **X** **ID** **1/2**
Code defining periods

SYNTAX: C0605

Used if needed to provide further information about the number and frequency of benefits.

CODE	DEFINITION
6	Hour
7	Day
21	Years
22	Service Year
23	Calendar Year
24	Year to Date
25	Contract
26	Episode
27	Visit
28	Outlier
29	Remaining
30	Exceeded
31	Not Exceeded
32	Lifetime
33	Lifetime Remaining
34	Month
35	Week

SITUATIONAL **HSD06** **616** **Number of Periods** **O** **N0** **1/3**
Total number of periods

INDUSTRY: ***Period Count***

SYNTAX: C0605

Used if needed to provide further information about the number and frequency of benefits.

SITUATIONAL **HSD07** **678** **Ship/Delivery or Calendar Pattern Code** **O** **ID** **1/2**
Code which specifies the routine shipments, deliveries, or calendar pattern

INDUSTRY: ***Delivery Frequency Code***

Used if needed to provide further information about the number and frequency of benefits.

CODE	DEFINITION
1	1st Week of the Month
2	2nd Week of the Month

3	3rd Week of the Month
4	4th Week of the Month
5	5th Week of the Month
6	1st & 3rd Weeks of the Month
7	2nd & 4th Weeks of the Month
8	1st Working Day of Period
9	Last Working Day of Period
A	Monday through Friday
B	Monday through Saturday
C	Monday through Sunday
D	Monday
E	Tuesday
F	Wednesday
G	Thursday
H	Friday
J	Saturday
K	Sunday
L	Monday through Thursday
M	Immediately
N	As Directed
O	Daily Mon. through Fri.
P	1/2 Mon. & 1/2 Thurs.
Q	1/2 Tues. & 1/2 Thurs.
R	1/2 Wed. & 1/2 Fri.
S	Once Anytime Mon. through Fri.
SG	Tuesday through Friday
SL	Monday, Tuesday and Thursday
SP	Monday, Tuesday and Friday
SX	Wednesday and Thursday
SY	Monday, Wednesday and Thursday
SZ	Tuesday, Thursday and Friday

T	1/2 Tue. & 1/2 Fri.
U	1/2 Mon. & 1/2 Wed.
V	1/3 Mon., 1/3 Wed., 1/3 Fri.
W	Whenever Necessary
X	1/2 By Wed., Bal. By Fri.
Y	None (Also Used to Cancel or Override a Previous Pattern)

SITUATIONAL **HSD08** **679** **Ship/Delivery Pattern Time Code** **O** **ID** **1/1**
Code which specifies the time for routine shipments or deliveries

INDUSTRY: ***Delivery Pattern Time Code***

Used if needed to provide further information about the number and frequency of benefits.

CODE	DEFINITION
A	1st Shift (Normal Working Hours)
B	2nd Shift
C	3rd Shift
D	A.M.
E	P.M.
F	As Directed
G	Any Shift
Y	None (Also Used to Cancel or Override a Previous Pattern)

IMPLEMENTATION

DEPENDENT ADDITIONAL IDENTIFICATION

Loop: **2110D — DEPENDENT ELIGIBILITY OR BENEFIT INFORMATION**

Usage: **SITUATIONAL**

Repeat: **9**

Notes:
1. **Use this segment to identify other or additional reference numbers for the entity identified. The type of reference number is determined by the qualifier in REF01.**
2. **Use this segment for reference identifiers related only to the EB loop that it is contained in (e.g. Other or Additional Payer's identifiers).**

Example: **REF*G1*653745725~**

STANDARD

REF Reference Identification

Level: Detail

Position: 140

Loop: 2110

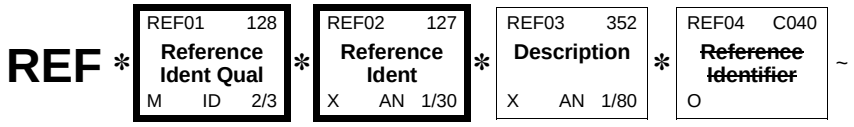
Requirement: Optional

Max Use: 9

Purpose: To specify identifying information

Syntax:
1. **R0203**
   At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

Use this code to specify or qualify the type of reference number that is following in REF02, REF03, or both.

Use "1L", "1W", "18", "49", ''6P'', "A6", "F6", ''IG'', "N6", and "NQ" only in an EB loop with EB01 = "R".

CODE	DEFINITION
18	**Plan Number**
1L	**Group or Policy Number**

			Use this code only if it cannot be determined if the number is a Group Number or a Policy number. Use codes "IG" or "6P" when they can be determined.			
			1W **Member Identification Number**			
			49 **Family Unit Number**			
			6P **Group Number**			
			9F **Referral Number**			
			A6 **Employee Identification Number**			
			F6 **Health Insurance Claim (HIC) Number**			
			G1 **Prior Authorization Number**			
			IG **Insurance Policy Number**			
			N6 **Plan Network Identification Number**			
			NQ **Medicaid Recipient Identification Number**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Dependent Eligibility or Benefit Identifier*** SYNTAX: R0203 **Use this information for the reference number as qualified by the preceding data element (REF01).**	**X**	**AN**	**1/30**
SITUATIONAL	**REF03**	**352**	**Description** A free-form description to clarify the related data elements and their content *INDUSTRY:* ***Plan Sponsor Name*** SYNTAX: R0203 **Use if available.**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

DEPENDENT ELIGIBILITY/BENEFIT DATE

Loop: **2110D — DEPENDENT ELIGIBILITY OR BENEFIT INFORMATION**

Usage: **SITUATIONAL**

Repeat: **20**

Notes:

1. **Use this segment to convey dates associated with the information contained in the corresponding Eligibility or Benefit Information (EB) loop.**

2. **When using codes "307" (Eligibility), "435" (Admission) or "472" (Service) at this level, it is implied that these dates apply only to the Eligibility or Benefit Information (EB) loop that it is located in. If there is a need to supply a global Eligibility, Admission or Service date, it must be provided in the DTP segment within the Dependent Name (Loop 2100D) loop.**

Example: **DTP*472*D8*19960624~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 150

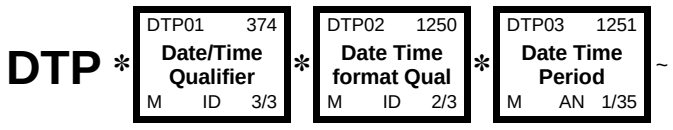
Loop: 2110

Requirement: Optional

Max Use: 20

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time	**M ID 3/3**

INDUSTRY: ***Date Time Qualifier***

CODE	DEFINITION
193	**Period Start**
194	**Period End**
198	**Completion**
290	**Coordination of Benefits**

			292	**Benefit**			
			295	**Primary Care Provider**			
			304	**Latest Visit or Consultation**			
			307	**Eligibility**			
			318	**Added**			
			348	**Benefit Begin**			
			349	**Benefit End**			
			356	**Eligibility Begin**			
			357	**Eligibility End**			
			435	**Admission**			
			472	**Service**			
			636	**Date of Last Update**			
			771	**Status**			

REQUIRED **DTP02** **1250** **Date Time Period Format Qualifier** **M ID 2/3**
Code indicating the date format, time format, or date and time format

SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03.

Use this code to specify the format of the date(s)/time(s) that follow in the next data element.

CODE	DEFINITION
D8	**Date Expressed in Format CCYYMMDD**
RD8	**Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD**

REQUIRED **DTP03** **1251** **Date Time Period** **M AN 1/35**
Expression of a date, a time, or range of dates, times or dates and times

*INDUSTRY: **Eligibility or Benefit Date Time Period***

Use this date for the date(s) as qualified by the preceding data elements.

IMPLEMENTATION

DEPENDENT REQUEST VALIDATION

Loop: **2110D — DEPENDENT ELIGIBILITY OR BENEFIT INFORMATION**

Usage: **SITUATIONAL**

Repeat: **9**

Notes:

1. **Use this segment when a request could not be processed at a system or application level and to indicate what action the originator of the request transaction should take.**

2. **Use this segment to indicate problems in processing the transaction specifically related to specific eligibility/benefit inquiry data contained in the original 270 transaction's dependent eligibility/benefit inquiry information loop (Loop 2110D).**

Example: **AAA*N**70*C~**

STANDARD

AAA Request Validation

Level: Detail

Position: 160

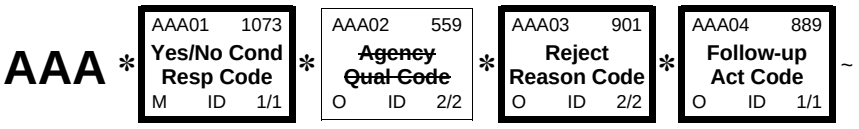
Loop: 2110

Requirement: Optional

Max Use: 9

Purpose: To specify the validity of the request and indicate follow-up action authorized

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AAA01**	**1073**	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response *INDUSTRY:* ***Valid Request Indicator*** **SEMANTIC:** AAA01 designates whether the request is valid or invalid. Code "Y" indicates that the code is valid; code "N" indicates that the code is invalid.	**M ID 1/1**

CODE	DEFINITION
N	**No** **Use this code to indicate that the request or an element in the request is not valid. The transaction has been rejected as identified by the code in AAA03.**

			Y	**Yes** **Use this code to indicate that the request is valid, however the transaction has been rejected as identified by the code in AAA03.**		
NOT USED	**AAA02**	**559**	**Agency Qualifier Code**	**O**	**ID**	**2/2**
REQUIRED	**AAA03**	**901**	**Reject Reason Code** Code assigned by issuer to identify reason for rejection	**O**	**ID**	**2/2**

Use this code for the reason why the transaction was unable to be processed successfully. This may indicate problems with the system, the application, or the data content.

CODE	DEFINITION
15	**Required application data missing**
52	**Service Dates Not Within Provider Plan Enrollment**
53	**Inquired Benefit Inconsistent with Provider Type**
54	**Inappropriate Product/Service ID Qualifier**
55	**Inappropriate Product/Service ID**
56	**Inappropriate Date**
57	**Invalid/Missing Date(s) of Service**
60	**Date of Birth Follows Date(s) of Service**
61	**Date of Death Precedes Date(s) of Service**
62	**Date of Service Not Within Allowable Inquiry Period**
63	**Date of Service in Future**
69	**Inconsistent with Patient's Age**
70	**Inconsistent with Patient's Gender**

REQUIRED	**AAA04**	**889**	**Follow-up Action Code** Code identifying follow-up actions allowed	**O**	**ID**	**1/1**

Use this code to instruct the recipient of the 271 about what action needs to be taken, if any, based on the validity code and the reject reason code (if applicable).

CODE	DEFINITION
C	**Please Correct and Resubmit**
N	**Resubmission Not Allowed**
R	**Resubmission Allowed**
W	**Please Wait 30 Days and Resubmit**
X	**Please Wait 10 Days and Resubmit**
Y	**Do Not Resubmit; We Will Hold Your Request and Respond Again Shortly**

IMPLEMENTATION

MESSAGE TEXT

Loop: **2110D — DEPENDENT ELIGIBILITY OR BENEFIT INFORMATION**

Usage: **SITUATIONAL**

Repeat: **10**

Advisory: **Under most circumstances, this segment is not sent.**

Notes:

1. **Free form text or description fields are not recommended because they require human interpretation.**

2. **Under no circumstances can an information source use the MSG segment to relay information that can be sent using codified information in existing data elements. If the need exists to use the MSG segment, it is highly recommended that the entity needing to use the MSG segment approach X12N with data maintenance to solve the business need without the use of the MSG segment.**

3. **Benefit Disclaimers are strongly discouraged. See section 1.3.10 Disclaimers Within the Transaction. Under no circumstances are more than one MSG segment to be used for a Benefit Disclaimer per individual response.**

Example: **MSG*Free form text is discouraged~**

STANDARD

MSG Message Text

Level: Detail

Position: 250

Loop: 2110

Requirement: Optional

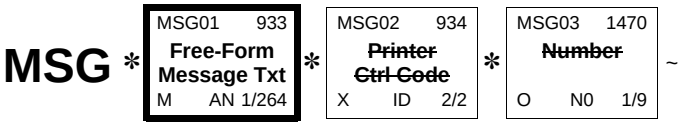
Max Use: 10

Purpose: To provide a free-form format that allows the transmission of text information

Syntax:

1. **C0302**
   If MSG03 is present, then MSG02 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**MSG01**	**933**	**Free-Form Message Text** Free-form message text *INDUSTRY:* ***Free Form Message Text***	**M AN 1/264**

NOT USED	MSG02	934	Printer Carriage Control Code	X	ID	2/2
NOT USED	MSG03	1470	Number	O	N0	1/9

IMPLEMENTATION

DEPENDENT ELIGIBILITY OR BENEFIT ADDITIONAL INFORMATION

Loop: **2115D — DEPENDENT ELIGIBILITY OR BENEFIT ADDITIONAL INFORMATION Repeat: 10**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Use this segment to begin the Dependent Eligibility or Benefit Additional Information looping structure.**
2. **This segment has two purposes. Information that was received in III segments in Loop 2110D of the 270 Inquiry and was used in the determination of the eligibility or benefit response must be returned. If information was provided in III segments of Loop 2110D but was not used in the determination of the eligibiltiy or benefits it must not be returned. This segment can also be used to identify limitations in the benefits explained in the corresponding Loop 2110D, such as if benefits are limited to a type of facility or for a specific diagnosis code.**
3. **Use this segment to identify Diagnosis codes and/or Facility Type as they relate to the information provided in the EB segment.**
4. **Use the III segment only if an information source can support this high level functionality.**
5. **Use this segment only one time for the Principal Diagnosis Code and only one time for Facility Type Code.**

Example: **III*BK*486~**
III*ZZ*21~

STANDARD

III Information

Level: Detail

Position: 260

Loop: 2115 **Repeat:** >1

Requirement: Optional

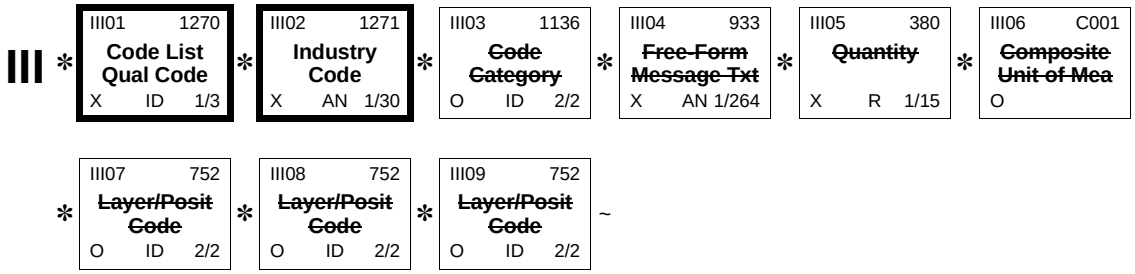
Max Use: 1

Purpose: To report information

Syntax:

1. **P0102**
   If either III01 or III02 is present, then the other is required.
2. **L030405**
   If III03 is present, then at least one of III04 or III05 are required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**III01**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list **SYNTAX:** P0102 **Use this code to specify if the code that is following in the III02 is a Principal Diagnosis Code, a Diagnosis Code or a Facility Type Code.**	**X ID 1/3**

CODE	DEFINITION
BF	**Diagnosis**
	CODE SOURCE 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure
BK	**Principal Diagnosis**
	CODE SOURCE 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure
ZZ	**Mutually Defined** **Use this code for Facility Type Code.** **See Appendix C for Code Source 237, Place of Service from Health Care Financing Administration Claim Form.**

REQUIRED	**III02**	**1271**	**Industry Code** Code indicating a code from a specific industry code list SYNTAX: P0102	**X**	**AN**	**1/30**

If III01 is either BK or BF, use this element for diagnosis code from code source 131.

If III01 is ZZ, use this element for codes identifying a place of service from code source 237. As a courtesy, the codes are listed below, however, the code list is thought to be complete at the time of publication of this implementation guideline. Since this list is subject to change, only codes contained in the document available from code source 237 are to be supported in this transaction and take precedence over any and all codes listed here.

11 Office
12 Home
21 Inpatient Hospital
22 Outpatient Hospital
23 Emergency Room - Hospital
24 Ambulatory Surgical Center
25 Birthing Center
26 Military Treatment Facility
31 Skilled Nursing Facility
32 Nursing Facility
33 Custodial Care Facility
34 Hospice
41 Ambulance - Land
42 Ambulance - Air or Water
50 Federally Qualified Health Center
51 Inpatient Psychiatric Facility
52 Psychiatric Facility Partial Hospitalization
53 Community Mental Health Center
54 Intermediate Care Facility/Mentally Retarded
55 Residential Substance Abuse Treatment Facility
56 Psychiatric Residential Treatment Center
60 Mass Immunization Center
61 Comprehensive Inpatient Rehabilitation Facility
62 Comprehensive Outpatient Rehabilitation Facility
65 End-Stage Renal Disease Treatment Facility
71 State or Local Public Health Clinic
72 Rural Health Clinic
81 Independent Laboratory
99 Other Unlisted Facility

NOT USED	**III03**	**1136**	**Code Category**	**O**	**ID**	**2/2**
NOT USED	**III04**	**933**	**Free-Form Message Text**	**X**	**AN**	**1/264**
NOT USED	**III05**	**380**	**Quantity**	**X**	**R**	**1/15**
NOT USED	**III06**	**C001**	**COMPOSITE UNIT OF MEASURE**	**O**		
NOT USED	**III07**	**752**	**Surface/Layer/Position Code**	**O**	**ID**	**2/2**
NOT USED	**III08**	**752**	**Surface/Layer/Position Code**	**O**	**ID**	**2/2**
NOT USED	**III09**	**752**	**Surface/Layer/Position Code**	**O**	**ID**	**2/2**

IMPLEMENTATION

DEPENDENT ELIGIBILITY OR BENEFIT INFORMATION

Loop: **2110D — DEPENDENT ELIGIBILITY OR BENEFIT INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Use this segment to identify the beginning of the Dependent Benefit Related Entity Name loop. Because both the subscriber's name loop and this loop begin with NM1 segments, the LS and LE segments are used to differentiate these two loops. Required if Loop 2120D is used.**

Example: **LS*2120~**

STANDARD

LS Loop Header

Level: Detail

Position: 330

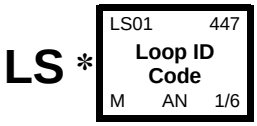
Loop: 2110

Requirement: Optional

Max Use: 1

Purpose: To indicate that the next segment begins a loop

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**LS01**	**447**	**Loop Identifier Code** The loop ID number given on the transaction set diagram is the value for this data element in segments LS and LE **This data element must have the value of "2120".**	**M AN 1/6**

IMPLEMENTATION

DEPENDENT BENEFIT RELATED ENTITY NAME

Loop: **2120D — DEPENDENT BENEFIT RELATED ENTITY NAME** **Repeat:** **1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Use this segment to identify an entity by name and/or identification number. This NM1 loop is used to identify a provider (such as the primary care provider), an individual, another payer, or another information source when applicable to the eligibility response.**

Example: **NM1*P3*1*JONES*MARCUS***MD*SV*111223333~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 340

Loop: 2120 **Repeat:** 1

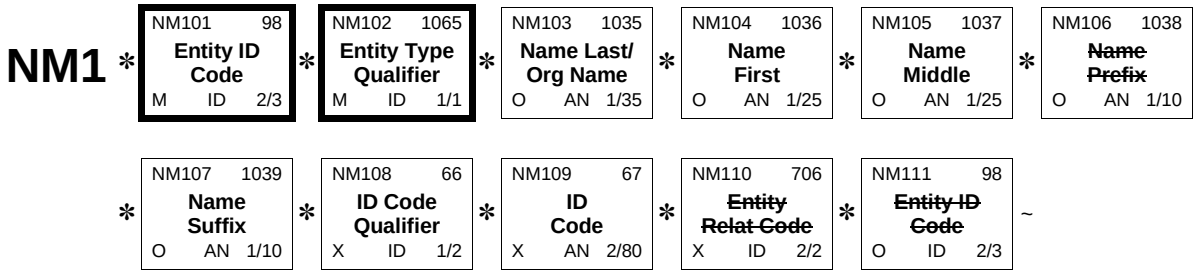
Requirement: Optional

Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

Syntax:
1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M ID 2/3**

CODE	DEFINITION
13	**Contracted Service Provider**

			1P	**Provider**			
			2B	**Third-Party Administrator**			
			36	**Employer**			
			73	**Other Physician**			
			FA	**Facility**			
			GP	**Gateway Provider**			
			IL	**Insured or Subscriber** **Use if identifying an insured or subscriber to a plan other than the information source (such as in a co-ordination of benefits situation).**			
			LR	**Legal Representative**			
			P3	**Primary Care Provider**			
			P4	**Prior Insurance Carrier**			
			P5	**Plan Sponsor**			
			PR	**Payer**			
			PRP	**Primary Payer**			
			SEP	**Secondary Payer**			
			TTP	**Tertiary Payer**			
			VN	**Vendor**			
			X3	**Utilization Management Organization**			
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103. **Use this code to indicate whether the entity is an individual person or an organization.**		**M**	**ID**	**1/1**
			CODE	**DEFINITION**			
			1	**Person**			
			2	**Non-Person Entity**			
SITUATIONAL	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name ***INDUSTRY:* *Benefit Related Entity Last or Organization Name*** **Use this name for the organization name if the entity type qualifier is a non-person entity. Otherwise, this will be the individual's last name.** **Use if available.**		**O**	**AN**	**1/35**

SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name	**O**	**AN**	**1/25**

INDUSTRY: ***Benefit Related Entity First Name***

Use this name only if available and NM102 is "1".

SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial	**O**	**AN**	**1/25**

INDUSTRY: ***Benefit Related Entity Middle Name***

Use this name only if available and NM102 is "1".

NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**AN**	**1/10**
SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name	**O**	**AN**	**1/10**

INDUSTRY: ***Benefit Related Entity Name Suffix***

Use name suffix only if available and NM102 is "1"; e.g., Sr., Jr., or III.

SITUATIONAL	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67)	**X**	**ID**	**1/2**

SYNTAX: P0809

If the entity being identified is a provider and the National Provider ID is mandated for use, code value "XX" must be used, otherwise, one of the other codes may be used. If the entity being identified is a payer and the HCFA National PlanID is mandated for use, code value "XV" must be used, otherwise, one of the other codes may be used. If the entity being identified is an individual, the "HIPAA Individual Identifier" must be used once this identifier has been adopted, otherwise, one of the other codes may be used.

Required when available.

CODE	DEFINITION
24	**Employer's Identification Number**
34	**Social Security Number** **The social security number may not be used for any Federally administered programs such as Medicare.**
46	**Electronic Transmitter Identification Number (ETIN)**
FA	**Facility Identification**
FI	**Federal Taxpayer's Identification Number**
MI	**Member Identification Number** **Use this code to identify the entity's Member Identification Number associated with a payer other than the information source in Loop 2100A. This code may only be used prior to the mandated use of code "ZZ".**
NI	**National Association of Insurance Commissioners (NAIC) Identification**

			PI	**Payor Identification**		
			PP	**Pharmacy Processor Number**		
			SV	**Service Provider Number**		
			XV	**Health Care Financing Administration National PlanID** ***Required if the National PlanID is mandated for use. Otherwise, one of the other listed codes may be used.***		
				CODE SOURCE **540:** Health Care Financing Administration National PlanID		
			XX	**Health Care Financing Administration National Provider Identifier** ***Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.***		
			ZZ	**Mutually Defined** **The value 'ZZ', when used in this data element shall be defined as "HIPAA Individual Identifier" once this identifier has been adopted. Under the Health Insurance Portability and Accountability Act of 1996, the Secretary of the Department of Health and Human Services must adopt a standard individual identifier for use in this transaction.**		
SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Benefit Related Entity Identifier*** SYNTAX: P0809 **Use this code for the reference number as qualified by the preceding data element (NM108).** **Required when available.**	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

DEPENDENT BENEFIT RELATED ENTITY ADDRESS

Loop: **2120D — DEPENDENT BENEFIT RELATED ENTITY NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Use this segment to identify address information for an entity.**
2. **Required when needed to further identify the entity or individual in loop 2120D NM1 and the information is available.**

Example: **N3*201 PARK AVENUE*SUITE 300~**

STANDARD

N3 Address Information

Level: Detail

Position: 360

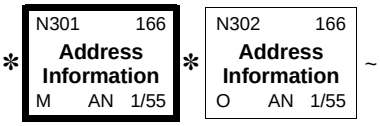
Loop: 2120

Requirement: Optional

Max Use: 1

Purpose: To specify the location of the named party

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N301**	**166**	**Address Information** Address information	**M**	**AN**	**1/55**
			INDUSTRY: ***Benefit Related Entity Address Line***			
			Use this information for the first line of the address information.			
SITUATIONAL	**N302**	**166**	**Address Information** Address information	**O**	**AN**	**1/55**
			INDUSTRY: ***Benefit Related Entity Address Line***			
			Use this information for the second line of the address information.			
			Required if a second address line exists.			

IMPLEMENTATION

DEPENDENT BENEFIT RELATED ENTITY CITY/STATE/ZIP CODE

Loop: **2120D — DEPENDENT BENEFIT RELATED ENTITY NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Use this segment to identify the city, state and ZIP Code for an entity.**
2. **Required when needed to further identify the entity or individual in loop 2120D NM1 and the information is available.**

Example: **N4*NEW YORK*NY*10003~**

STANDARD

N4 Geographic Location

Level: Detail

Position: 370

Loop: 2120

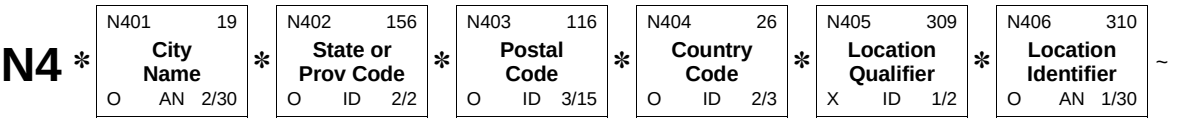
Requirement: Optional

Max Use: 1

Purpose: To specify the geographic place of the named party

Syntax:
1. **C0605**
   If N406 is present, then N405 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**N401**	**19**	**City Name** Free-form text for city name *INDUSTRY:* ***Benefit Related Entity City Name*** **COMMENT:** A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location. **Use this text for the city name of the entity's address.**	**O AN 2/30**

SITUATIONAL **N402** **156** **State or Province Code** **O** **ID** **2/2**
Code (Standard State/Province) as defined by appropriate government agency

INDUSTRY: ***Benefit Related Entity State Code***

COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada.

CODE SOURCE **22:** States and Outlying Areas of the U.S.

Use this code for the state code of the entity's address.

SITUATIONAL **N403** **116** **Postal Code** **O** **ID** **3/15**
Code defining international postal zone code excluding punctuation and blanks (zip code for United States)

INDUSTRY: ***Benefit Related Entity Postal Zone or ZIP Code***

CODE SOURCE **51:** ZIP Code

Use this code for the ZIP or Postal Code of the entity's address.

SITUATIONAL **N404** **26** **Country Code** **O** **ID** **2/3**
Code identifying the country

CODE SOURCE **5:** Countries, Currencies and Funds

Use this code to specify the country of the entity's address, if other than the United States.

SITUATIONAL **N405** **309** **Location Qualifier** **X** **ID** **1/2**
Code identifying type of location

SYNTAX: C0605

Use only for CHAMPUS/TRICARE or CHAMPVA purposes.

CODE	DEFINITION
RJ	**Region** **Use this code only to communicate the Department of Defense Health Service Region in N406.**

SITUATIONAL **N406** **310** **Location Identifier** **O** **AN** **1/30**
Code which identifies a specific location

INDUSTRY: ***Department of Defense Health Service Region Code***

SYNTAX: C0605

Use only for CHAMPUS/TRICARE or CHAMPVA to communicate the Department of Defense Health Service Region for a Primary Care Provider.

CODE SOURCE DOD1: Military Health Systems Functional Area Manual - Data.

IMPLEMENTATION

DEPENDENT BENEFIT RELATED ENTITY CONTACT INFORMATION

Loop: **2120D — DEPENDENT BENEFIT RELATED ENTITY NAME**

Usage: **SITUATIONAL**

Repeat: **3**

Notes:

1. **Use this segment when needed to identify a contact name and/or communications number for the entity identified. This segment allows for three contact numbers to be listed. This segment is used when the information source wishes to provide a contact for the entity identified in loop 2120D NM1.**

   If telephone extension is sent, it should always be in the occurrence of the communications number following the actual phone number. See the example for an illustration.

2. **If this segment is used, at a minimum either PER02 must be used or PER03 and PER04 must be used. It is recommended that at least PER02, PER03 and PER04 are sent if this segment is used.**

3. **When the communication number represents a telephone number in the United States and other countries using the North American Dialing Plan (for voice, data, fax, etc.), the communication number should always include the area code and phone number using the format AAABBBCCCC. Where AAA is the area code, BBB is the telephone number prefix, and CCCC is the telephone number (e.g. (534)224-2525 would be represented as 5342242525). The extension, when applicable, should be included in the communication number immediately after the telephone number.**

4. **By definition of the standard, if PER03 is used, PER04 is required.**

Example: **PER*IC*BILLING DEPT*TE*2128763654*EX*2104*FX*2128769304~**

STANDARD

PER Administrative Communications Contact

Level: Detail

Position: 380

Loop: 2120

Requirement: Optional

Max Use: 3

Purpose: To identify a person or office to whom administrative communications should be directed

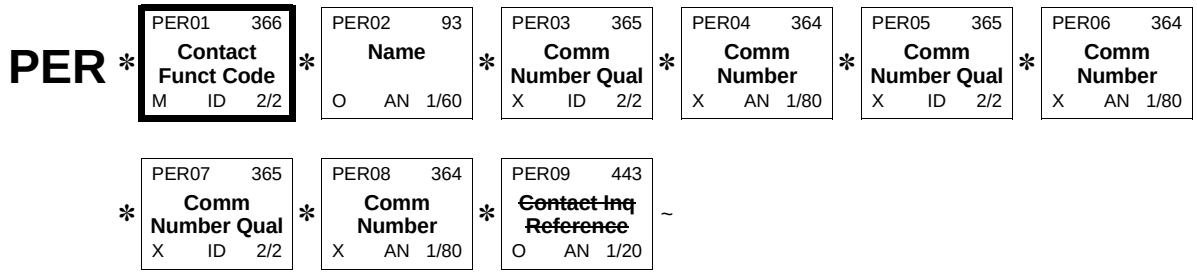
Syntax:

1. **P0304**
   If either PER03 or PER04 is present, then the other is required.

2. **P0506**
   If either PER05 or PER06 is present, then the other is required.

3. **P0708**
   If either PER07 or PER08 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PER01**	**366**	**Contact Function Code** Code identifying the major duty or responsibility of the person or group named **Use this code to specify the type of person or group to which the contact number applies.** CODE: **IC** — DEFINITION: **Information Contact**	**M ID 2/2**
SITUATIONAL	**PER02**	**93**	**Name** Free-form name *INDUSTRY:* ***Benefit Related Entity Contact Name*** **Use this name for the individual's name or group's name to use when contacting the individual or organization.** **Use this data element when the name of the individual to contact is not already defined or is different than the name within the prior name segment (e.g. N1 or NM1).**	**O AN 1/60**
SITUATIONAL	**PER03**	**365**	**Communication Number Qualifier** Code identifying the type of communication number SYNTAX: P0304 **Use this code to specify what type of communication number is following.** CODE / DEFINITION: **ED** — **Electronic Data Interchange Access Number** **EM** — **Electronic Mail** **FX** — **Facsimile** **TE** — **Telephone** **WP** — **Work Phone Number**	**X ID 2/2**

SITUATIONAL **PER04** **364** **Communication Number** **X** **AN** **1/80**
Complete communications number including country or area code when applicable

INDUSTRY: ***Benefit Related Entity Communication Number***

SYNTAX: P0304

Required when PER02 is not present or when a contact number is to be sent in addition to the contact name. Use this number for the communication number as qualified by the preceding data element.

The format for US domestic phone numbers is:
AAABBBCCCC
AAA = Area Code
BBBCCCC = Local Number

SITUATIONAL **PER05** **365** **Communication Number Qualifier** **X** **ID** **2/2**
Code identifying the type of communication number

SYNTAX: P0506

Use this code to specify what type of communication number is following.

CODE	DEFINITION
ED	**Electronic Data Interchange Access Number**
EM	**Electronic Mail**
EX	**Telephone Extension**
FX	**Facsimile**
TE	**Telephone**
WP	**Work Phone Number**

SITUATIONAL **PER06** **364** **Communication Number** **X** **AN** **1/80**
Complete communications number including country or area code when applicable

INDUSTRY: ***Benefit Related Entity Communication Number***

SYNTAX: P0506

Required when an additional contact number is to be sent. Use this number for the communication number as qualified by the preceding data element.

The format for US domestic phone numbers is:
AAABBBCCCC
AAA = Area Code
BBBCCCC = Local Number

SITUATIONAL **PER07** **365** **Communication Number Qualifier** **X** **ID** **2/2**
Code identifying the type of communication number

SYNTAX: P0708

Use this code to specify what type of communication number is following.

CODE	DEFINITION
ED	**Electronic Data Interchange Access Number**

			EM	**Electronic Mail**			
			EX	**Telephone Extension**			
			FX	**Facsimile**			
			TE	**Telephone**			
			WP	**Work Phone Number**			
SITUATIONAL	**PER08**	**364**	**Communication Number** Complete communications number including country or area code when applicable *INDUSTRY:* ***Benefit Related Entity Communication Number*** SYNTAX: P0708 **Required when an additional contact number is to be sent. Use this number for the communication number as qualified by the preceding data element.** **The format for US domestic phone numbers is:** **AAABBBCCCC** **AAA = Area Code** **BBBCCCC = Local Number**	**X**	**AN**	**1/80**
NOT USED	**PER09**	**443**	**Contact Inquiry Reference**	**O**	**AN**	**1/20**

IMPLEMENTATION

DEPENDENT BENEFIT RELATED PROVIDER INFORMATION

Loop: **2120D — DEPENDENT BENEFIT RELATED ENTITY NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Use this segment when needed to either to identify a specific provider or associate a specialty type related to the service identified in the 2110D loop.**
2. **If identifying a specific provider, use this segment to convey specific information about a provider's role in the eligibility/benefit being inquired about when the provider is not the information receiver. For example, if the information receiver is a hospital and a referring provider must be identified, this is the segment where the referring provider would be identified.**
3. **If identifying a specific provider, this segment contains reference identification numbers, all of which may be used up until the time the National Provider Identifier (NPI) is mandated for use. After the NPI is mandated, only the code for National Provider Identifier may be used.**
4. **If identifying a type of specialty associated with the services identified in loop 2110D, use code ZZ in PRV02 and the appropriate code in PRV03.**
5. **PRV02 qualifies PRV03.**

Example: **PRV*PE*EI*9991234567~**
PRV*PE*ZZ*203BA0504N~

STANDARD

PRV Provider Information

Level: Detail

Position: 390

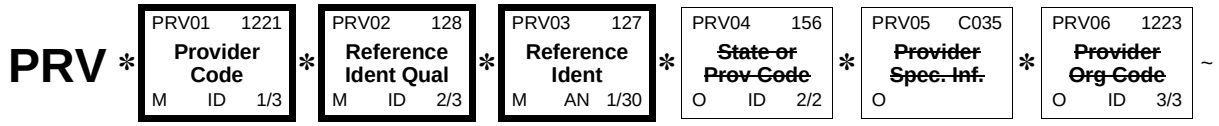
Loop: 2120

Requirement: Optional

Max Use: 1

Purpose: To specify the identifying characteristics of a provider

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	PRV01	1221	**Provider Code** Code indentifying the type of provider	M	ID	1/3

CODE	DEFINITION
AT	Attending
BI	Billing
CO	Consulting
CV	Covering
H	Hospital
HH	Home Health Care
LA	Laboratory
OT	Other Physician
P1	Pharmacist
P2	Pharmacy
PC	Primary Care Physician
PE	Performing
R	Rural Health Clinic
RF	Referring
SK	Skilled Nursing Facility

REQUIRED	PRV02	128	**Reference Identification Qualifier** Code qualifying the Reference Identification	M	ID	2/3

If the National Provider ID is mandated for use, code value "HPI" must be used, otherwise one of the other code values may be used.

ZZ is used to indicate the "Health Care Provider Taxonomy" code list (provider specialty code) which is available on the Washington Publishing Company web site: http://www.wpc-edi.com. This taxonomy is maintained by the Blue Cross Blue Shield Association and ASC X12N TG2 WG15.

CODE	DEFINITION
9K	**Servicer** **Use this code for the identification number assigned by the information source to be used by the information receiver in health care transactions.**
D3	**National Association of Boards of Pharmacy Number** CODE SOURCE **307:** National Association of Boards of Pharmacy Number
EI	**Employer's Identification Number**

			HPI	**Health Care Financing Administration National Provider Identifier** **Required value when identifying a specific provider when the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.**		
				CODE SOURCE **537:** Health Care Financing Administration National Provider Identifier		
			SY	**Social Security Number** **The social security number may not be used for any Federally administered programs such as Medicare.**		
			TJ	**Federal Taxpayer's Identification Number**		
			ZZ	**Mutually Defined** **Health Care Provider Taxonomy Code list.**		
REQUIRED	**PRV03**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Provider Identifier*** **Use this reference number as qualified by the preceding data element (PRV02).**	**M**	**AN**	**1/30**
NOT USED	**PRV04**	**156**	**State or Province Code**	**O**	**ID**	**2/2**
NOT USED	**PRV05**	**C035**	**PROVIDER SPECIALTY INFORMATION**	**O**		
NOT USED	**PRV06**	**1223**	**Provider Organization Code**	**O**	**ID**	**3/3**

IMPLEMENTATION

LOOP TRAILER

Loop: **2110D — DEPENDENT ELIGIBILITY OR BENEFIT INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Use this segment to identify the end of the Dependent Benefit Related Entity Name loop. Because both the subscriber's name loop and this loop begin with NM1 segments, the LS and LE segments are used to differentiate these two loops. Required if Loop 2120D is used.**

Example: **LE*2120~**

STANDARD

LE Loop Trailer

Level: Detail

Position: 400

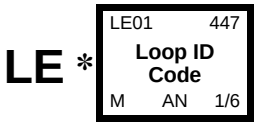
Loop: 2110

Requirement: Optional

Max Use: 1

Purpose: To indicate that the loop immediately preceding this segment is complete

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**LE01**	**447**	**Loop Identifier Code** The loop ID number given on the transaction set diagram is the value for this data element in segments LS and LE **This data element must have the value of "2120".**	**M AN 1/6**

IMPLEMENTATION

TRANSACTION SET TRAILER

Usage: **REQUIRED**

Repeat: **1**

Notes: **1. Use this segment to mark the end of a transaction set and provide control information on the total number of segments included in the transaction set.**

Example: **SE*52*0001~**

STANDARD

SE Transaction Set Trailer

Level: Detail

Position: 410

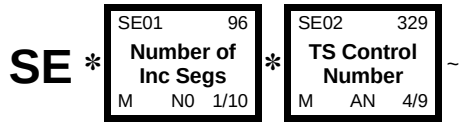
Loop: ____

Requirement: Mandatory

Max Use: 1

Purpose: To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning (ST) and ending (SE) segments)

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**SE01**	**96**	**Number of Included Segments** Total number of segments included in a transaction set including ST and SE segments *INDUSTRY:* ***Transaction Segment Count***	**M N0 1/10**
REQUIRED	**SE02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set	**M AN 4/9**
			The transaction set control numbers in ST02 and SE02 must be identical. This unique number also aids in error resolution research. Start with a number, for example "0001", and increment from there. This number must be unique within a specific functional group (segments GS through GE) and interchange, but can repeat in other groups and interchanges.	

4 EDI Transmission Examples for Different Business Uses

4.1 Business Scenario 1

The following information is associated with the information source, information receiver, subscriber, and dependent used in the following examples:

Payer (Information Source)

ABC Company Payer
Payer Identification Number
842610001

Provider (Information Receiver)
Clinic

Bone and Joint Clinic Provider
Service Provider Number 2000035
Facility Network Identification Number 234899
Address Seattle, WA, 98123
Communication Contact Name Billing Department
Phone Number 206-555-1212, Extension 2805 and FAX 206-555-1213

Provider (Information Receiver)

Individual Physician

Marcus Jones Provider
Service Provider Number 0202034
Provider Plan Network Identification Number 129
Communication Contact Name M. Murphy
Phone Number 206-555-1212, Extension 3694 and FAX 206-555-1214

Subscriber

Robert B. Smith Subscriber (Subscriber/Patient)
Member Identification Number 11122333301
Group or Policy Number 599119

Dependent

Mary Lou Smith Dependent (Patient)
Member Identification Number 11122333303
Social Security Number 003221234

Example A — Request

Request by a physician for the patient's eligibility for an office visit (subscriber)

This is an example of an eligibility request from an individual provider to a payer. The physician is inquiring if the patient (the subscriber) has visit coverage. The request is from Marcus Jones to the ABC Company.

ST*270*1234~	Transaction Set ID Code = 270 (Health Care Eligibility Inquiry) Transaction Set Control Number = 1234
BHT*0022*13*10001234*1 9990501*1319~	Hierarchical Structure Code = 0022 (Information Source, Information Receiver, Subscriber, Dependent) Transaction Set Purpose Code = 13 (Request) Identification Reference Identification = 10001234 Date = 19990501 (May 1, 1999) Time = 1:19pm
HL*120*1~**	Hierarchical ID Number = 1 Hierarchical Parent ID Number = * not used Hierarchical Level Code = 20 (Information Source) Hierarchical Child Code = 1
NM1*PR*2*ABC COMPANY* ****PI*842610001~	Entity Identifier Code = PR (Payer) Entity Type Qualifier = 2 (Non-person) Last Name = ABC Company First Name = * not used Middle Name = * not used Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = PI (Payer Identification) Identification Code = 842610001
HL*2*1*21*1~	Hierarchical ID Number = 2 Hierarchical Parent ID Number = 1 Hierarchical Level Code = 21 Hierarchical Child Code = 1

NM1*1P*1*JONES*MARCUS* ***SV*0202034~	Entity Identifier Code = 1P (Provider) Entity Type Qualifier = 1 (Person) Last Name = Jones First Name = Marcus Middle Name = * not used Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = SV Service Provider Number Identification Code = 0202034
HL*3*2*22*0~	Hierarchical ID Number = 3 Hierarchical Parent ID Number = 2 Hierarchical Level Code = 22 Hierarchical Child Code = 0
TRN*1*93175-012547*987 7281234~	Trace Type Code = 1 (Current Transaction Trace Number) Reference Identification = 93175-012547 Originating Company Identifier = 9877281234 Reference Identification = * not used
NM1*IL*1*SMITH*ROBERT* B*MI*11122333301~**	Entity Identifier Code = IL (Insured or Subscriber) Entity Type = 1 (Person) Last Name = Smith First Name = Robert Middle Name = B Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = MI (Member Identification Number) Identification Code = 11122333301
REF*1L*599119~	Reference Identification Qualifier = 1L (Group or Policy Number) Reference Identification = 599119 Description = * not used
DMG*D8*19430519*M~	Date Time Period Format = D8 (Date Expressed in Format CCYYMMDD) Date Time Period = 19430519 Gender Code = M (Male)
DTP*472*D8*19990501~	Date/Time Qualifier = 472 (Service) Date Time Period Format Qualifier D8 (Dates Expressed in Format CCYYMMDD) Date Time Period = 19990501(May 1, 1999)

EQ*98FAM~**	Service Type Code = 98 (Professional) Physician Visit - Office Composite Medical Procedure Identifier = * not used Coverage Level Code = FAM (Family) Insurance Type Code =* not used
SE*14*1234~	Number of Included Segments = 14 Transaction Set Control Number = 1234

Example B — Request

Request by a physician for the patient's benefits for a routine physical (dependent)

This is an example of an eligibility request from an individual provider to a payer. The physician is inquiring if the patient (the dependent) has coverage. The request is from Marcus Jones to the ABC Company.

ST*270*1234~	Transaction Set ID Code = 270 (Health Care Eligibility Inquiry) Transaction Set Control Number = 1234
BHT*0022*13*10001234*1 9990501*1319~	Hierarchical Structure Code = 0022 (Information Source, Information Receiver, Subscriber, Dependent) Transaction Set Purpose Code = 13 (Request) Reference Identification = 10001234 Date = 19990501 (May 1, 1999) Time = 1:19pm
HL*120*1~**	Hierarchical ID Number = 1 Hierarchical Parent ID Number = * not used Hierarchical Level Code = 20 Hierarchical Child Code = 1
NM1*PR*2*ABC COMPANY** *PI*842610001~**	Entity Identifier Code = PR (Payer) Entity Type Qualifier = 2 (Non-person) Last Name = ABC Company First Name = * not used Middle Name = * not used Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = PI (Payer Identification) Identification Code = 842610001
HL*2*1*21*1~	Hierarchical ID Number = 2 Hierarchical Parent ID Number =1 Hierarchical Level Code = 21 Hierarchical Child Code = 1

NM1*1P*1*JONES*MARCUS* ***SV*0202034~	Entity Identifier Code = 1P (Provider) Entity Type Qualifier = 1 (Person) Last Name = Jones First Name = Marcus Middle Name = * not used Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = SV Service Provider Number Identification Code = 0202034
REF*N5*129~	Reference Identification Qualifier = N5 (Provider Plan Network Identification Number) Reference Identification = 129 Description = not used
N3*55 HIGH STREET~	Address Information = 55 High Street Address Information = * not used
N4*SEATTLE*WA*98123~	City Name = Seattle State = WA ZIP = 98123
PER*IC*MARY MURPHY*TE*2065551212* EX*3694*FX* 2065551214~	Contact Function Code = IC (Information Contact) Name = Mary Murphy Communication Number Qualifier = TE (Telephone Number) Communication Number = 2065551212 Communication Number Qualifier = EX (Telephone Extension) Communication Number = 3694 Communication Number Qualifier = FX (Facsimile Number) Communication Number = 2065551214
HL*3*2*22*1~	Hierarchical ID Number = 3 Hierarchical Parent ID Number = 2 Hierarchical Level Code = 22 Hierarchical Child Code = 1
TRN*1*93175-012547*987 7281234~	Trace Type Code = 1 (Current Transaction Trace Number) Reference Identification = 93175-012547 Originating Company Identifier = 9877281234 Reference Identification = * not used

NM1*IL*1*SMITH*ROBERT*B*MI*11122333301~**	Entity Identifier Code = IL (Insured Or Subscriber) Entity Type = 1 (Person) Last Name = Smith First Name = Robert Middle Name = B Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = MI (Member Identification Number) Identification Code = 11122333301
REF*1L*599119~	Reference Identification Qualifier = 1L (Group or Policy Number) Reference Identification = 599119 Description = not used
N3*29 FREMONT ST*APT # 1~	Address Information = 29 Fremont St Address Information = Apt # 1
N4*PEACE*NY*10023~	City Name = Peace State = NY (New York) ZIP = 10023
DMG*D8*19430519*M~	Date Time Period Format = D8 (Date Expressed in Format CCYYMMDD) Date Time Period = 19430519 Gender Code = M (Male)
HL*4*3*23*0~	Hierarchical ID Number = 4 Hierarchical Parent ID Number = 3 Hierarchical Level Code = 23 Hierarchical Child Code = 0
TRN*1*93175-012547*9877281234*RADIOLOGY~	Trace Type Code = 1 Reference Identification = 94175-012547 Originating Company Identifier = 9877281234 Reference Identification = Radiology
NM1*03*1*SMITH*MARY LOU~	Entity Identifier Code = 03 (Dependent) Entity Type = 1 (Person) Last Name = Smith First Name = Mary Lou Middle Name = * not used Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = * not used Identification Code = * not used

REF*SY*003221234~	Reference Identification Qualifier = SY (Social Security Number) Reference Identification = 003221234 Description = * not used
N3*29 FREMONT ST*APT # 1~	Address Information = 29 Fremont St Address Information = Apt # 1
N4*PEACE*NY*10023~	City Name = Peace State = NY (New York) ZIP = 10023
DMG*D8*19781014*F~	Date Time Period Format = D8 (Date Expressed in Format CCYYMMDD) Date Time Period = 19781014 Gender Code = F (Female)
INS*N*19~	Yes/No Condition or Response Code = N (No) Individual Relationship Code = 19 (Child)
DTP*472*D8*19990501~	Date/Time Qualifier = 472 (Service) Date Time Period Format Qualifier = D8 (Date Expressed in Format CCYYMMDD) Date Time Period = 19990501 (May 1, 1999)
EQ*81FAM~**	Service Type Code = 81 (Routine Physical) Composite Medical Procedure Identifier = * not used Coverage Level Code = FAM (Family) Insurance Type Code = not used
SE*28*1234~	Number of Included Segments = 28 Transaction Set Control Number = 1234

Example C — Request

Request by a clinic for the patient's general benefits (subscriber)

This is an example of an eligibility request from a clinic to a payer. The clinic is inquiring if the patient (the subscriber) has insurance coverage. The request is from the Bone and Joint Clinic to the ABC Company.

ST*270*1234~	Transaction Set ID Code = 270 (Health Care Eligibility Inquiry) Transaction Set Control Number = 1234
BHT*0022*13*10001234*19990501*1319~	Hierarchical Structure Code = 0022 (Information Source, Information Receiver, Subscriber, Dependent) Transaction Set Purpose Code = 13 (Request) Reference Identification = 10001234 Date = 19990501 (May 1, 1999) Time = 1:19pm
HL*120*1~**	Hierarchical ID Number = 1 Hierarchical Parent ID Number = * not used Hierarchical Level Code = 20 Hierarchical Child Code = 1
NM1*PR*2*ABC COMPANY***PI*842610001~**	Entity Identifier Code = PR (Payer) Entity Type Qualifier = 2 (Non-person) Last Name = ABC Company First Name = * not used Middle Name = * not used Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = PI (Payer Identification) Identification Code = 842610001
HL*2*1*21*1~	Hierarchical ID Number = 2 Hierarchical Parent ID Number = 1 Hierarchical Level Code = 21 Hierarchical Child Code = 1
NM1*1P*2*BONE AND JOINT CINIC***SV*2000035~**	Entity Identifier Code = 1P (Provider) Entity Type Qualifier = 2 (Non-person) Last Name = Bone and Joint Clinic First Name = * not used Middle Name = * not used Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = SV Service Provider Number Identification Code = 2000035

REF*N7*234899~	Reference Identification Qualifier = N7 (Facility Network Identification Number) Reference Identification = 234899 Description = not used
N3*55*HIGH STREET~	Address Information = 55 High Street Address Information = not used
N4*SEATTLE*WA*98123~	City Name = SEATTLE State = WA ZIP = 98123
HL*3*2*22*0~	Hierarchical ID Number = 3 Hierarchical Parent ID Number = 2 Hierarchical Level Code = 22 Hierarchical Child Code = 0
TRN*1*93175-012547*9877281234~	Trace Type Code = 1 (Current Transaction Trace Number) Reference Identification = 93175-012547 Originating Company Identifier = 9877281234 Reference Identification = not used
NM1*IL*1*SMITH*ROBERT*B*MI*11122333301~**	Entity Identifier Code = IL (Insured or Subscriber) Entity Type = 1 (Person) Last Name = Smith First Name = Robert Middle Name = B Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = MI (Member Identification Number) Identification Code = 11122333301
REF*1L*599119~	Reference Identification Qualifier = 1L (Group or Policy Number) Reference Identification = 599119 Description = not used
DMG*D8*19430519*M~	Date Time Period Format = D8 (Date Expressed in Format CCYYMMDD) Date Time Period = 19430519 Gender Code = M (Male)

DTP*472*RD8*19990501-1 9990515~	Date/Time Qualifier = 472 (Service) Date Time Period Format Qualifier RD8 (Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD) Date Time Period = 19990501-19990515 (May 1, 1999 to May 15, 1999)
EQ*30FAM~**	Service Type Code = 30 Health Benefit Plan Coverage Composite Medical Procedure Identifier = * not used Coverage Level Code = FAM (Family) Insurance Type Code = not used
SE*17*1234~	Number of Included Segments = 17 Transaction Set Control Number = 1234

Example D — Request

Request by a clinic for the patient's surgical benefits (dependent)

This is an example of an eligibility request from a clinic to a payer. The clinic is inquiring if the patient (the dependent) has insurance coverage for surgery. The request is from the Bone and Joint Clinic to the ABC Company.

ST*270*1234~	Transaction Set ID Code = 270 (Health Care Eligibility Inquiry) Transaction Set Control Number = 1234
BHT*0022*13*10001234*19990501*1319~	Hierarchical Structure Code = 0022 (Information Source, Information Receiver, Subscriber, Dependent) Transaction Set Purpose Code = 13 (Request) Reference Identification = 10001234 Date = 19990501 (May 1, 1999) Time = 1:19pm
HL*120*1~**	Hierarchical ID Number = 1 Hierarchical Parent ID Number = * not used Hierarchical Level Code = 20 Hierarchical Child Code = 1
NM1*PR*2*ABC COMPANY**PI*842610001~**	Entity Identifier Code = PR (Payer) Entity Type Qualifier = 2 (Non-person) Last Name = ABC Company First Name = * not used Middle Name = * not used Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = PI (Payer Identification) Identification Code = 842610001
HL*2*1*21*1~	Hierarchical ID Number = 2 Hierarchical Parent ID Number = 1 Hierarchical Level Code = 21 Hierarchical Child Code = 1
NM1*1P*2*BONE AND JOINT CLINIC**SV*2000035~**	Entity Identifier Code = 1P (Provider) Entity Type Qualifier = 2 (Non-person) Last Name = Bone and Joint Clinic First Name = * not used Middle Name = * not used Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = SV Service Provider Number Identification Code = 2000035

REF*N7*234899~	Reference Identification Qualifier = N7 (Facility Network Identification Number) Reference Identification = 234899 Description = not used
N3*55 HIGH STREET~	Address Information = 55 High Street Address Information = not used
N4*SEATTLE*WA*98123~	City Name = Seattle State = WA ZIP = 98123
PER*IC*BILLING DEPT*TE*2065551212*EX *2805*FX*2065551213~	Contact Function Code = IC (Information Contact) Name = Billing Dept. Communication Number Qualifier = TE (Telephone Number) Communication Number = 2065551212 Communication Number Qualifier = EX (Telephone Extension) Communication Number = 2805 Communication Number Qualifier = FX (Facsimile Number) Communication Number = 2065551213
PRV*PE*TJ*991231234 *WA~	Provider Code = PE (Performing) Reference Identification Qualifier = TJ (Federal Taxpayer's Identification Number) Reference Identification = 991231234 State or Province Code = WA (Washington) Provider Specialty Information = not used Provider Organization Code = not used
HL*3*2*22*1~	Hierarchical ID Number = 3 Hierarchical Parent ID Number = 2 Hierarchical Level Code = 22 Hierarchical Child Code = 1
TRN*1*93175-012547*987 7281234~	Trace Type Code = 1 (Current Transaction Trace Number) Reference Identification = 93175-012547 Originating Company Identifier = 9877281234 Reference Identification = * not used

NM1*IL*1*SMITH*ROBERT*B*MI*11122333301~**	Entity Identifier Code = IL (Insured or Subscriber) Entity Type = 1 (Person) Last Name = Smith First Name = Robert Middle Name = B Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = MI (Member Identification Number) Identification Code = 11122333301
REF*1L*599119~	Reference Identification Qualifier = 1L (Group or Policy Number) Reference Identification = 599119 Description = not used
N3*29 FREMONT ST*APT # 1~	Address Information = 29 Fremont St Address Information = Apt # 1
N4*PEACE*NY*10023~	City Name = Peace State = NY (New York) ZIP = 10023
DMG*D8*19430519*M~	Date Time Period Format = D8 (Date Expressed in Format CCYYMMDD) Date Time Period = 19430519 Gender Code = M (Male)
HL*4*3*23*0~	Hierarchical ID Number = 4 Hierarchical Parent ID Number = 3 Hierarchical Level Code = 23 Hierarchical Child Code = 0
TRN*1*93175-012547*9877281234*RADIOLOGY~	Trace Type Code = 1 Reference Identification = 94175-012547 Originating Company Identifier = 9877281234 Reference Identification = Radiology
NM1*03*1*SMITH*MARY LOU~	Entity Identifier Code = 03 (Dependent) Entity Type = 1 (Person) Last Name = Smith First Name = Mary Lou Middle Name = * not used Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = * not used Identification Code = * not used

REF*SY*003221234~	Reference Identification Qualifier = SY (Social Security Number) Reference Identification = 003221234 Description = not used
N3*29 FREMONT ST*APT # 1~	Address Information = 29 Fremont St Address Information = Apt # 1
N4*PEACE*NY*10023~	City Name = Peace State = NY (New York) ZIP = 10023
DMG*D8*19781014*F~	Date Time Period Format = D8 (Date Expressed in Format CCYYMMDD) Date Time Period = 19781014 Gender Code = F (Female)
INS*N*19~	Yes/No Condition or Response Code = N (No) Individual Relationship Code = 19 (Child)
DTP*472*D8*19990501~	Date/Time Qualifier = 472 (Service) Date Time Period Format Qualifier = D8 (Date Expressed in Format CCYYMMDD) Date Time Period = 19990501 (May 1, 1999)
EQ*2~	Service Type Code = 2 (Surgical) Composite Medical Procedure Identifier = not used Coverage Level Code = not used Insurance Type Code = not used
SE*29*1234~	Number of Included Segments = 29 Transaction Set Control Number = 1234

4.2 Business Scenario 2

The following information is associated with the information source, information receiver, subscriber, dependent used in the following examples:

Payer (Information Source)	ABC Company Payer Payer Identification Number 842610001
Provider (Information Receiver) Clinic	Bone and Joint Clinic Provider Service Provider Number 2000035 Facility Network Identification Number 234899 Address Seattle, WA, 98123 Communication Contact Name Billing Department Phone Number 206-555-1212, Extension 2805 and FAX 206-555-1213
Provider (Information Receiver) Individual Physician	Marcus Jones Provider Service Provider Number 0202034 Provider Plan Network Identification Number 129 Communication Contact Name M. Murphy Phone Number 206-555-1212, Extension 3694 and FAX 206-555-1213
Subscriber	Robert B. Smith Subscriber (May Be Patient) Member Identification Number 11122333301 Group or Policy Number 599119
Dependent	Mary Lou Smith Dependent (Patient) Member Identification Number 11122333303 Social Security Number 003221234

Example A - Response

Response in regard to the provider not being eligible for inquiries from the payer

This is an example of an eligibility response from a payer to a provider. The response is from the ABC Company to Marcus Jones. The request validation segment is used in this example to indicate that the provider is not eligible for inquiries.

ST*271*1234~	Transaction Set ID Code = 271 (Health Care Eligibility Response) Transaction Set Control Number = 1234
BHT*0022*11*10001234*19990501*1319~	Hierarchical Structure Code = 0022 (Information Source, Information Receiver, Subscriber, Dependent) Transaction Set Purpose Code = 11 (Response) Reference Identification = 10001234 Date = 19990501 (May 1, 1999) Time Transaction Type Code = 1:19pm
HL*120*1~**	Hierarchical ID Number = 1 Hierarchical Parent ID Number = * not used Hierarchical Level Code = 20 Hierarchical Child Code = 1
NM1*PR*2*ABC COMPANY***PI*842610001~**	Entity Identifier Code = PR (Payer) Entity Type Qualifier = 2 (Non-person) Last Name = ABC Company First Name = * not used Middle Name = * not used Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = PI (Payer Identification) Identification Code = 842610001
HL*2*1*21*0~	Hierarchical ID Number = 2 Hierarchical Parent ID Number = 1 Hierarchical Level Code = 21 Hierarchical Child Code = 1

NM1*1P*1*JONES*MARCUS* ***SV*0202034~	Entity Identifier Code = 1P (Provider) Entity Type Qualifier = 1 (Person) Last Name = Jones First Name = Marcus Middle Name = * not used Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = SV Service Provider Number Identification Code = 0202034
AAA*Y50*N~**	Validity Code = Y (Yes) Agency Qualifier Code = * not used Reject Reason Code = 50 (Provider Ineligible For Inquiries) Follow-Up Action Code = N (Resubmission Not Allowed)
SE*8*1234~	Number of Included Segments = 8 Transaction Set Control Number = 1234

Example B - Response

Response in regard to the patient's (dependent) benefits for a routine physical from the payer

This is an example of an eligibility response from a payer to an individual provider. The payer is responding to the physician about the patient's (the dependent) insurance coverage. The response is from the ABC Company to Marcus Jones.

ST*271*1234~	Transaction Set ID Code = 271 (Health Care Eligibility Response) Transaction Set Control Number = 1234
BHT*0022*11*10001234*19990501*1319~	Hierarchical Structure Code = 0022 (Information Source, Information Receiver, Subscriber, Dependent) Transaction Set Purpose Code = 11 (Response) Reference Identification = 10001234 Date = 19990501 (May 1, 1999) Time = 1:19pm
HL*120*1~**	Hierarchical ID Number = 1 Hierarchical Parent ID Number = * not used Hierarchical Level Code = 20 Hierarchical Child Code = 1
NM1*PR*2*ABC COMPANY**PI*842610001~**	Entity Identifier Code = PR (Payer) Entity Type Qualifier = 2 (Non-person)Last Name = ABC Company First Name = * not used Middle Name = * not used Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = PI (Payer Identification) Identification Code = 84261001
HL*2*1*21*1~	Hierarchical ID Number = 2 Hierarchical Parent ID Number = 1 Hierarchical Level Code = 21 Hierarchical Child Code = 1

NM1*1P*1*JONES*MARCUS* ***SV*0202034~	Entity Identifier Code = 1P (Provider) Entity Type Qualifier = 1 (Person) Last Name = Jones First Name = Marcus Middle Name = * not used Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = SV Service Provider Number Identification Code = 0202034
REF*N5*129~	Reference Identification Qualifier = N5 (Provider Plan Network Identification Number) Reference Identification = 129 Description = * not used
HL*3*2*22*1~	Hierarchical ID Number = 3 Hierarchical Parent ID Number = 2 Hierarchical Level Code = 22 Hierarchical Child Code = 1
TRN*2*93175-012547*987 7281234~	Trace Type Code = 2 (Referenced Transactions Trace Numbers) Reference Identification = 93175-012547 Originating Company Identifier = 9877281234
NM1*IL*1*SMITH*ROBERT B*MI*11122333301~**	Entity Identifier Code = IL (Insured Or Subscriber) Entity Type = 1 (Person) Last Name = Smith First Name = Robert Middle Name = B Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = MI (Member Identification Number) Identification Code = 11122333301
REF*1L*599119~	Reference Identification Qualifier = 1L (Group or Policy Number) Reference Identification = 599119 Description = not used
N3*29 FREMONT ST*APT # 1~	Address Information = 29 Freemont St Address Information = Apt # 1

N4*PEACE*NY*10023~	City Name = Peace State = NY (New York) ZIP = 10023
DMG*D8*19430519*M~	Date Time Period Format = D8 (Date Expressed in Format CCYYMMDD) Date Time Period = 19430519 Gender Code = M (Male)
HL*4*3*23*0~	Hierarchical ID Number = 4 Hierarchical Parent ID Number = 3 Hierarchical Level Code = 23 Hierarchical Child Code = 0
TRN*2*93175-012547*9877281234*RADIOLOGY~	Trace Type Code = 2 (Referenced Transaction Trace Number) Reference Identification = 94175-012547 Originating Company Identifier = 9877281234 Reference Identification = Radiology
NM1*03*1*SMITH*MARY LOU~	Entity Identifier Code = 03 (Dependent) Entity Type = 1 (Person) Last Name = Smith First Name = Mary Lou Middle Name = * not used Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = * not used Identification Code = * not used
REF*SY*003221234~	Reference Identification Qualifier = SY (Social Security Number) Reference Identification = 003221234 Description = not used
N3*29 FREMONT ST* APT # 1~	Address Information = 29 Freemont St Address Information = Apt # 1
N4*PEACE*NY*10023~	City Name = Peace State = NY (New York) ZIP = 10023
DMG*D8*19881014*F~	Date Time Period Format = D8 (Date Expressed in Format CCYYMMDD) Date Time Period = 19881014 Gender Code = F (Female)

INS*N*19~	Yes/No Condition or Response Code = N (No) Individual Relationship Code = 19 (Child)
DTP*472*D8*19950624~	Date/Time Qualifier = 472 (Service) Date Time Period Format Qualifier = D8 (Date Expressed in Format CCYYMMDD) Date Time Period = 19950624
EB*1*FAM*30*GP~	Eligibility or Benefit Information = 1 (Active Coverage) Coverage Level Code = FAM (Family) Service Type Code = 30 Health Benefit Plan Coverage Insurance Type Code = GP (Group Policy)
EB*B81*GP***15****Y~**	Eligibility or Benefit Information = B (Co-payment) Coverage Level Code = * not used Service Type Code = 81 (Routine Physical) Insurance Type Code = GP (Group Policy) Plan Coverage Description = * not used Time Period Qualifier = * not used Monetary Amount = 15.00 Percent = * not used Quantify Qualifier = * not used Quantify = * not used Yes/No condition or response code = Y (Authorization or Certification is Required)
EB*L~	Eligibility or Benefit Information = L (Primary Care Physician)
LS*2120~	Loop Identifier Code = 2120

NM1*P3*1*BROWN*TOM*D JR*SV*222333444~**	Entity Identifier Code = P3 (Primary Care Provider) Entity Type Qualifier = 1 (Person) Last Name = Brown First Name = Tom Middle Name = D Name Prefix = * not used Name Suffix = JR Identification Code Qualifier = SV Service Provider Number Identification Code = 222333444
PER*IC*BILLING DEPT* TE*2065556666~	Contact Function Code = IC (Information Contact) Name = Billing Dept Communication Number Qualifier = TE (Telephone Number) Communication Number = 2065556666
LE*2120~	Loop Identifier Code = 2120
SE*30*1234~	Number of Included Segments = 30 Transaction Set Control Number = 1234

Example C - Response

Response in regard to the patient's (subscriber) general benefits from the payer

This is an example of an eligibility response from the payer to a clinic. The payer is responding to the clinic's inquiry of the about the insurance coverage of the subscriber, (the patient). The response is from the ABC Company to the Bone and Joint Clinic.

ST*271*1234~	Transaction Set ID Code = 271 (Health Care Eligibility Response) Transaction Set Control Number = 1234
BHT*0022*11*10001234*19990501*1319~	Hierarchical Structure Code = 0022 (Information Source, Information Receiver, Subscriber, Dependent) Transaction Set Purpose Code = 11 (Response) Reference Identification = 10001234 Date = 19990501 (May 1, 1999) Time = 1:19pm
HL*120*1~**	Hierarchical ID Number = 1 Hierarchical Parent ID Number = * not used Hierarchical Level Code = 20 Hierarchical Child Code = 1
NM1*PR*2*ABC COMPANY***PI*842610001~**	Entity Identifier Code = PR (Payer) Entity Type Qualifier = 2 (Non-person) Last Name = ABC Company First Name = * not used Middle Name = * not used Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = PI (Payer Identification) Identification Code = 842610001
HL*2*1*21*1~	Hierarchical ID Number = 2 Hierarchical Parent ID Number = 1 Hierarchical Level Code = 21 Hierarchical Child Code = 1

NM1*1P*2*BONE AND JOINT CLINIC* **SV*2000035~**	Entity Identifier Code = 1P (Provider) Entity Type Qualifier = 2 (Non-person) Last Name = Bone and Joint Clinic First Name = * not used Middle Name = * not used Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = SV Service Provider Number Identification Code = 2000035
REF*N7*234899~	Reference Identification Qualifier = N7 (Facility Network Identification Number) Reference Identification = 234899 Description = * not used
HL*3*2*22*0~	Hierarchical ID Number = 3 Hierarchical Parent ID Number = 2 Hierarchical Level Code = 22 Hierarchical Child Code = 0
TRN*2*93175-012547*9877281234~	Trace Type Code = 2 (Referenced Transaction Trace Number) Reference Identification = 93175-012547 Originating Company Identifier = 9877281234 Reference Identification = * not used
NM1*IL*1*SMITH*ROBERT*B*MI*11122333301~**	Entity Identifier Code = IL (Insured or Subscriber) Entity Type = 1 (Person) Last Name = Smith First Name = Robert Middle Name = B Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = MI (Member Identification Number) Identification Code = 11122333301
REF*1L*599119~	Reference Identification Qualifier = 1L (Group or Policy Number) Reference Identification = 599119 Description = not used
DMG*D8*19430519*M~	Date Time Period Format = D8 (Date Expressed in Format CCYYMMDD) Date Time Period = 19430519 Gender Code = M (Male)

DTP*472*RD8*19990501-19990515~	Date/Time Qualifier = 472 (Service) Date Time Period Format Qualifier RD8 (Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD) Date Time Period = 19990501-19990515 (May 1, 1999 to May 15, 1999)
EB*1*FAM*30*GP~	Eligibility or Benefit Information = 1 (Active Coverage) Coverage Level Code = FAM (Family) Service Type Code = 30 Health Benefit Plan Coverage Insurance Type Code = GP (Group Policy)
SE*15*1234~	Number of Included Segments = 15 Transaction Set Control Number = 1234

Example D - Response

Response in regard to the patient's (dependent) surgical benefits from the payer

This is an example of an eligibility response from a payer to a clinic. The payer is responding to the clinic about the patient's (dependent) surgical insurance coverage. The response is from the ABC Company to the Bone and Joint Clinic.

ST*271*1234~	Transaction Set ID Code = 271 (Health Care Eligibility Response) Transaction Set Control Number = 1234
BHT*0022*11*10001234*19990501*1319~	Hierarchical Structure Code = 0022 (Information Source, Information Receiver, Subscriber, Dependent) Transaction Set Purpose Code = 11 (Response) Reference Identification = 10001234 Date = 19990501 (May 1, 1999) Time = 1:19pm
HL*120*1~**	Hierarchical ID Number = 1 Hierarchical Parent ID Number = * not used Hierarchical Level Code = 20 Hierarchical Child Code = 1
NM1*PR*2*ABC COMPANY***PI*842610001~**	Entity Identifier Code = PR (Payer) Entity Type Qualifier = 2 (Non-person) Last Name = ABC Company First Name = * not used Middle Name = * not used Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = PI (Payer Identification) Identification Code = 842610001
HL*2*1*21*1~	Hierarchical ID Number = 2 Hierarchical Parent ID Number = 1 Hierarchical Level Code = 21 Hierarchical Child Code = 1
NM1*1P*2*BONE AND JOINT CLINIC****SV*2000035~**	Entity Identifier Code = 1P (Provider) Entity Type Qualifier = 2 (Non-person) Last Name = Bone and Joint Clinic First Name = * not used Middle Name = * not used Name Prefix = * not used

	Name Suffix = * not used Identification Code Qualifier = SV Service Provider Number Identification Code = 2000035
REF*N7*234899~	Reference Identification Qualifier = N7 (Facility Network Identification Number) Reference Identification = 234899 Description = not used
HL*3*2*22*1~	Hierarchical ID Number = 3 Hierarchical Parent ID Number = 2 Hierarchical Level Code = 22 Hierarchical Child Code = 1
TRN*2*93175-012547*9877281234~	Trace Type Code = 2 (Referenced Transaction Trace Number) Reference Identification = 93175-012547 Originating Company Identifier = 9877281234 Reference Identification = * not used
NM1*IL*1*SMITH*ROBERT*B*MI*11122333301~**	Entity Identifier Code = IL (Insured Or Subscriber) Entity Type = 1 (Person) Last Name = Smith First Name = Robert Middle Name = B Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = MI (Member Identification Number) Identification Code = 11122333301
REF*1L*599119~	Reference Identification Qualifier = 1L (Group or Policy Number) Reference Identification = 599119 Description = not used
N3*29 FREMONT ST*APT # 1~	Address Information = 29 Freemont St Address Information = Apt # 1
N4*PEACE*NY*10023~	City Name = Peace State = NY (New York) ZIP = 10023
DMG*D8*19430519*M~	Date Time Period Format = D8 (Date Expressed in Format CCYYMMDD) Date Time Period = 19430519 Gender Code = M (Male)

HL*4*3*23*0~	Hierarchical ID Number = 4 Hierarchical Parent ID Number = 3 Hierarchical Level Code = 23 Hierarchical Child Code = 0
TRN*2*93175-012547*9877281234*RADIOLOGY~	Trace Type Code = 2 Reference Identification = 94175-012547 Originating Company Identifier = 9877281234 Reference Identification = Radiology
NM1*03*1*SMITH*MARY LOU~	Entity Identifier Code = 03 (Dependent) Entity Type = 1 (Person) Last Name = Smith First Name = Mary Lou Middle Name = * not used Name Prefix = * not used Name Suffix = * not used Identification Code Qualifier = * not used Identification Code = * not used
REF*SY*003221234~	Reference Identification Qualifier = SY (Social Security Number) Reference Identification = 003221234 Description = not used
N3*29 FREMONT ST*APT # 1~	Address Information = 29 Freemont St Address Information = Apt # 1
N4*PEACE*NY*10023~	City Name = Peace State = NY (New York) ZIP = 10023
DMG*D8*19881014*F~	Date Time Period Format = D8 (Date Expressed in Format CCYYMMDD) Date Time Period = 19881014 Gender Code = F (Female)
INS*N*19~	Yes/No Condition or Response Code = N (No) Individual Relationship Code = 19 (Child)
DTP*472*D8*19990501~	Date/Time Qualifier = 472 (Service) Date Time Period Format Qualifier = D8 (Date Expressed in Format CCYYMMDD) Date Time Period = 19990501 (May 1, 1999)

EB*1*FAM*30*GP~	Eligbility or Benefit Information = 1 (Active Coverage) Coverage Level Code = FAM (Family) Service Type Code = 30 Health Benefit Plan Coverage Insurance Type Code = GP (Group Policy)
EB*B2*GP***15****Y~**	Eligibility or Benefit Information = B (Co-payment) Coverage Level Code = * not used Service Type Code = 2 (Surgical) Insurance Type Code = GP (Group Policy) Plan Coverage Description = * not used Time Period Qualifier = * not used Monetary Amount = 15.00 Percent = * not used Quantify Qualifier = * not used Quantify = * not used Yes/No condition or response code = Y (Authorization or Certification Is Required)
EB*C*IND**23*400~**	Eligibility or Benefit Information = C (Deductible) Coverage Level Code = IND - Individual Service Type Code = * not used Insurance Type Code = * not used Plan Coverage Description = * not used Time Period Qualifier = 23 Calendar year Monetary Amount = $400.00
EB*L~	Eligibility or Benefit Information = L (Primary Care Physician)
LS*2120~	Loop Identifier Code = 2120

NM1*P3*1*BROWN*TOM*D JR*SV*222333444~**	Entity Identifier Code = P3 (Primary Care Provider) Entity Type Qualifier = 1 (Person) Last Name = Brown First Name = Tom Middle Name = D Name Prefix = * not used Name Suffix = JR Identification Code Qualifier = SV Service Provider Number Identification Code = 222333444
PER*IC*BILLING DEPT* TE*2065556666~	Contact Function Code = IC (Information Contact) Name = Billing Dept. Communication Number Qualifier = TE (Telephone Number) Communication Number = 2065556666
LE*2120~	Loop Identifier Code = 2120
SE*31*1234~	Number of Included Segments = 31 Transaction Set Control Number = 1234

A ASC X12 Nomenclature

A.1 Interchange and Application Control Structures

A.1.1 Interchange Control Structure

The transmission of data proceeds according to very strict format rules to ensure the integrity and maintain the efficiency of the interchange. Each business grouping of data is called a transaction set. For instance, a group of benefit enrollments sent from a sponsor to a payer is considered a transaction set.

Each transaction set contains groups of logically related data in units called segments. For instance, the N4 segment used in the transaction set conveys the city, state, ZIP Code, and other geographic information. A transaction set contains multiple segments, so the addresses of the different parties, for example, can be conveyed from one computer to the other. An analogy would be that the transaction set is like a freight train; the segments are like the train's cars; and each segment can contain several data elements the same as a train car can hold multiple crates.

The sequence of the elements within one segment is specified by the ASC X12 standard as well as the sequence of segments in the transaction set. In a more conventional computing environment, the segments would be equivalent to records, and the elements equivalent to fields.

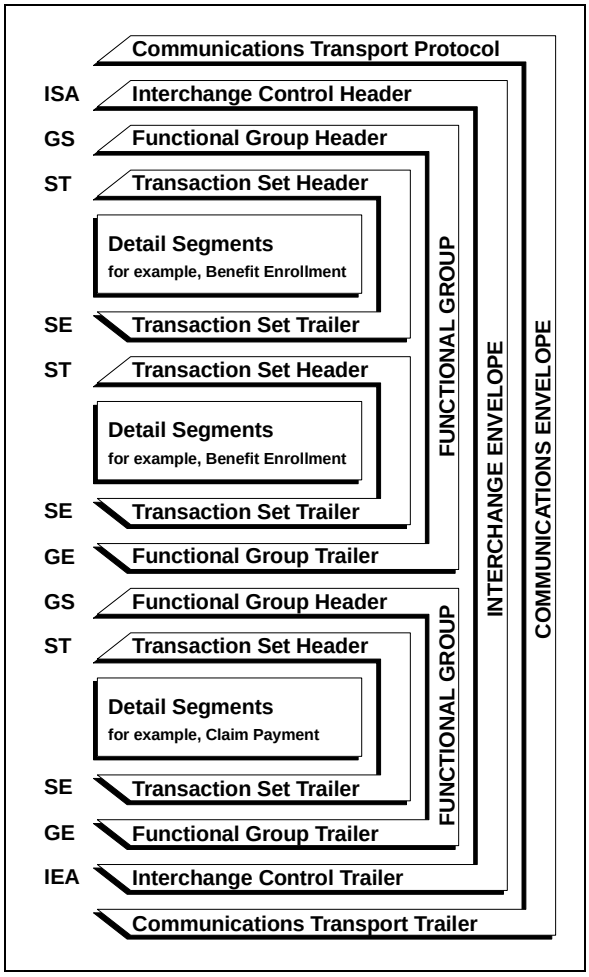


Figure A1. Transmission Control Schematic

Similar transaction sets, called "functional groups," can be sent together within a transmission. Each functional group is prefaced by a group start segment; and a functional group is terminated by a group end segment. One or more functional groups are prefaced by an interchange header and followed by an interchange trailer. Figure A1, Transmission Control Schematic, illustrates this interchange control.

The interchange header and trailer segments envelop one or more functional groups or interchange-related control segments and perform the following functions:

1. Define the data element separators and the data segment terminator.
2. Identify the sender and receiver.
3. Provide control information for the interchange.
4. Allow for authorization and security information.

A.1.2 Application Control Structure Definitions and Concepts

A.1.2.1 Basic Structure

A data element corresponds to a data field in data processing terminology. The data element is the smallest named item in the ASC X12 standard. A data segment corresponds to a record in data processing terminology. The data segment begins with a segment ID and contains related data elements. A control segment has the same structure as a data segment; the distinction is in the use. The data segment is used primarily to convey user information, but the control segment is used primarily to convey control information and to group data segments.

A.1.2.2 Basic Character Set

The section that follows is designed to have representation in the common character code schemes of EBCDIC, ASCII, and CCITT International Alphabet 5. The ASC X12 standards are graphic-character-oriented; therefore, common character encoding schemes other than those specified herein may be used as long as a common mapping is available. Because the graphic characters have an implied mapping across character code schemes, those bit patterns are not provided here.

The basic character set of this standard, shown in figure A2, Basic Character Set, includes those selected from the uppercase letters, digits, space, and special characters as specified below.

A...Z	**0...9**	**!**	**“**	**&**	**’**	**(**	**)**	*****	**+**
,	**-**	**.**	**/**	**:**	**;**	**?**	**=**	**“ ” (space)**	

Figure A2. Basic Character Set

A.1.2.3 Extended Character Set

An extended character set may be used by negotiation between the two parties and includes the lowercase letters and other special characters as specified in figure A3, Extended Character Set.

a..z	**%**	**~**	**@**	**[**	**]**	**_**	**{**
}	****	**|**	**<**	**>**	**#**	**$**	

Figure A3. Extended Character Set

Note that the extended characters include several character codes that have multiple graphical representations for a specific bit pattern. The complete list appears

in other standards such as CCITT S.5. Use of the USA graphics for these codes presents no problem unless data is exchanged with an international partner. Other problems, such as the translation of item descriptions from English to French, arise when exchanging data with an international partner, but minimizing the use of codes with multiple graphics eliminates one of the more obvious problems.

A.1.2.4 Control Characters

Two control character groups are specified; they have only restricted usage. The common notation for these groups is also provided, together with the character coding in three common alphabets. In the matrix A1, Base Control Set, the column IA5 represents CCITT V.3 International Alphabet 5.

A.1.2.5 Base Control Set

The base control set includes those characters that will not have a disruptive effect on most communication protocols. These are represented by:

NOTATION	NAME	EBCDIC	ASCII	IA5
BEL	bell	2F	07	07
HT	horizontal tab	05	09	09
LF	line feed	25	0A	0A
VT	vertical tab	0B	0B	0B
FF	form feed	0C	0C	0C
CR	carriage return	0D	0D	0D
FS	file separator	1C	1C	1C
GS	group separator	1D	1D	1D
RS	record separator	1E	1E	1E
US	unit separator	1F	1F	1F
NL	new line	15		

Matrix A1. Base Control Set

The Group Separator (GS) may be an exception in this set because it is used in the 3780 communications protocol to indicate blank space compression.

A.1.2.6 Extended Control Set

The extended control set includes those that may have an effect on a transmission system. These are shown in matrix A2, Extended Control Set.

NOTATION	NAME	EBCDIC	ASCII	IA5
SOH	start of header	01	01	01
STX	start of text	02	02	02
ETX	end of text	03	03	03
EOT	end of transmission	37	04	04
ENQ	enquiry	2D	05	05
ACK	acknowledge	2E	06	06
DC1	device control 1	11	11	11
DC2	device control 2	12	12	12
DC3	device control 3	13	13	13
DC4	device control 4	3C	14	14
NAK	negative acknowledge	3D	15	15
SYN	synchronous idle	32	16	16
ETB	end of block	26	17	17

Matrix A2. Extended Control Set

A.1.2.7 Delimiters

A delimiter is a character used to separate two data elements (or subelements) or to terminate a segment. The delimiters are an integral part of the data.

Delimiters are specified in the interchange header segment, ISA. The ISA segment is a 105 byte fixed length record. The data element separator is byte number 4; the component element separator is byte number 105; and the segment terminator is the byte that immediately follows the component element separator.

Once specified in the interchange header, the delimiters are not to be used in a data element value elsewhere in the interchange. For consistency, this implementation guide uses the delimiters shown in matrix A3, Delimiters, in all examples of EDI transmissions.

CHARACTER	NAME	DELIMITER
*	Asterisk	Data Element Separator
:	Colon	Subelement Separator
~	Tilde	Segment Terminator

Matrix A3. Delimiters

The delimiters above are for illustration purposes only and are not specific recommendations or requirements. Users of this implementation guide should be aware that an application system may use some valid delimiter characters within the application data. Occurrences of delimiter characters in transmitted data within a data element can result in errors in translation programs. The existence of asterisks (*) within transmitted application data is a known issue that can affect translation software.

A.1.3 Business Transaction Structure Definitions and Concepts

The ASC X12 standards define commonly used business transactions (such as a health care claim) in a formal structure called “transaction sets.” A transaction set is composed of a transaction set header control segment, one or more data segments, and a transaction set trailer control segment. Each segment is composed of the following:

- A unique segment ID
- One or more logically related data elements each preceded by a data element separator
- A segment terminator

A.1.3.1 Data Element

The data element is the smallest named unit of information in the ASC X12 standard. Data elements are identified as either simple or component. A data element that occurs as an ordinally positioned member of a composite data structure is identified as a component data element. A data element that occurs in a segment outside the defined boundaries of a composite data structure is identified as a simple data element. The distinction between simple and component data elements is strictly a matter of context because a data element can be used in either capacity.

Data elements are assigned a unique reference number. Each data element has a name, description, type, minimum length, and maximum length. For ID type data elements, this guide provides the applicable ASC X12 code values and their descriptions or references where the valid code list can be obtained.

Each data element is assigned a minimum and maximum length. The length of the data element value is the number of character positions used except as noted for numeric, decimal, and binary elements.

The data element types shown in matrix A4, Data Element Types, appear in this implementation guide.

SYMBOL	TYPE
Nn	Numeric
R	Decimal
ID	Identifier
AN	String
DT	Date
TM	Time
B	Binary

Matrix A4. Data Element Types

A.1.3.1.1 Numeric

A numeric data element is represented by one or more digits with an optional leading sign representing a value in the normal base of 10. The value of a numeric data element includes an implied decimal point. It is used when the position of the decimal point within the data is permanently fixed and is not to be transmitted with the data.

This set of guides denotes the number of implied decimal positions. The representation for this data element type is “Nn” where N indicates that it is numeric and n indicates the number of decimal positions to the right of the implied decimal point.

If n is 0, it need not appear in the specification; N is equivalent to N0. For negative values, the leading minus sign (-) is used. Absence of a sign indicates a positive value. The plus sign (+) should not be transmitted.

EXAMPLE
A transmitted value of 1234, when specified as numeric type N2, represents a value of 12.34.

Leading zeros should be suppressed unless necessary to satisfy a minimum length requirement. The length of a numeric type data element does not include the optional sign.

A.1.3.1.2 Decimal

A decimal data element may contain an explicit decimal point and is used for numeric values that have a varying number of decimal positions. This data element type is represented as “R.”

The decimal point always appears in the character stream if the decimal point is at any place other than the right end. If the value is an integer (decimal point at the right end) the decimal point should be omitted. For negative values, the leading minus sign (-) is used. Absence of a sign indicates a positive value. The plus sign (+) should not be transmitted.

Leading zeros should be suppressed unless necessary to satisfy a minimum length requirement. Trailing zeros following the decimal point should be suppressed unless necessary to indicate precision. The use of triad separators (for example, the commas in 1,000,000) is expressly prohibited. The length of a decimal type data element does not include the optional leading sign or decimal point.

EXAMPLE
A transmitted value of 12.34 represents a decimal value of 12.34.

A.1.3.1.3 Identifier

An identifier data element always contains a value from a predefined list of codes that is maintained by the ASC X12 Committee or some other body recognized by the Committee. Trailing spaces should be suppressed unless they are necessary to satisfy a minimum length. An identifier is always left justified. The representation for this data element type is “ID.”

A.1.3.1.4 String

A string data element is a sequence of any characters from the basic or extended character sets. The significant characters shall be left justified. Leading spaces, when they occur, are presumed to be significant characters. Trailing spaces should be suppressed unless they are necessary to satisfy a minimum length. The representation for this data element type is “AN.”

A.1.3.1.5 Date

A date data element is used to express the standard date in either YYMMDD or CCYYMMDD format in which CC is the first two digits of the calendar year, YY is the last two digits of the calendar year, MM is the month (01 to 12), and DD is the day in the month (01 to 31). The representation for this data element type is “DT.” Users of this guide should note that all dates within transactions are 8-character dates (millennium compliant) in the format CCYYMMDD. The only date data element that is in format YYMMDD is the Interchange Date data element in the ISA segment, and also used in the TA1 Interchange Acknowledgment, where the century can be readily interpolated because of the nature of an interchange header.

A.1.3.1.6 Time

A time data element is used to express the ISO standard time HHMMSSd..d format in which HH is the hour for a 24 hour clock (00 to 23), MM is the minute (00 to 59), SS is the second (00 to 59) and d..d is decimal seconds. The representation for this data element type is “TM.” The length of the data element determines the format of the transmitted time.

EXAMPLE
Transmitted data elements of four characters denote HHMM. Transmitted data elements of six characters denote HHMMSS.

A.1.3.2 Composite Data Structure

The composite data structure is an intermediate unit of information in a segment. Composite data structures are composed of one or more logically related simple data elements, each, except the last, followed by a sub-element separator. The final data element is followed by the next data element separator or the segment terminator. Each simple data element within a composite is called a component.

Each composite data structure has a unique four-character identifier, a name, and a purpose. The identifier serves as a label for the composite. A composite data structure can be further defined through the use of syntax notes, semantic notes, and comments. Each component within the composite is further characterized by a reference designator and a condition designator. The reference designators and the condition designators are described below.

A.1.3.3 Data Segment

The data segment is an intermediate unit of information in a transaction set. In the data stream, a data segment consists of a segment identifier, one or more composite data structures or simple data elements each preceded by a data element separator and succeeded by a segment terminator.

Each data segment has a unique two- or three-character identifier, a name, and a purpose. The identifier serves as a label for the data segment. A segment can be further defined through the use of syntax notes, semantic notes, and comments. Each simple data element or composite data structure within the segment is further characterized by a reference designator and a condition designator.

A.1.3.4 Syntax Notes

Syntax notes describe relational conditions among two or more data segment units within the same segment, or among two or more component data elements within the same composite data structure. For a complete description of the relational conditions, See A.1.3.8, Condition Designator.

A.1.3.5 Semantic Notes

Simple data elements or composite data structures may be referenced by a semantic note within a particular segment. A semantic note provides important additional information regarding the intended meaning of a designated data element, particularly a generic type, in the context of its use within a specific data segment. Semantic notes may also define a relational condition among data elements in a segment based on the presence of a specific value (or one of a set of values) in one of the data elements.

A.1.3.6 Comments

A segment comment provides additional information regarding the intended use of the segment.

A.1.3.7 Reference Designator

Each simple data element or composite data structure in a segment is provided a structured code that indicates the segment in which it is used and the sequential position within the segment. The code is composed of the segment identifier followed by a two-digit number that defines the position of the simple data element or composite data structure in that segment.

For purposes of creating reference designators, the composite data structure is viewed as the hierarchical equal of the simple data element. Each component data element in a composite data structure is identified by a suffix appended to the reference designator for the composite data structure of which it is a member.

This suffix is a two-digit number, prefixed with a hyphen, that defines the position of the component data element in the composite data structure.

EXAMPLE

- The first simple element of the CLP segment would be identified as CLP01.
- The first position in the SVC segment is occupied by a composite data structure that contains seven component data elements, the reference designator for the second component data element would be SVC01-02.

A.1.3.8 Condition Designator

This section provides information about X12 standard conditions designators. It is provided so that users will have information about the general standard. Implementation guides may impose other conditions designators. See implementation guide section 3.1 Presentation Examples for detailed information about the implementation guide Industry Usage requirements for compliant implementation.

Data element conditions are of three types: mandatory, optional, and relational. They define the circumstances under which a data element may be required to be present or not present in a particular segment.

DESIGNATOR	DESCRIPTION
M- Mandatory	The designation of mandatory is absolute in the sense that there is no dependency on other data elements. This designation may apply to either simple data elements or composite data structures. If the designation applies to a composite data structure, then at least one value of a component data element in that composite data structure shall be included in the data segment.
O- Optional	The designation of optional means that there is no requirement for a simple data element or composite data structure to be present in the segment. The presence of a value for a simple data element or the presence of value for any of the component data elements of a composite data structure is at the option of the sender.
X- Relational	Relational conditions may exist among two or more simple data elements within the same data segment based on the presence or absence of one of those data elements (presence means a data element must not be empty). Relational conditions are specified by a condition code (see table below) and the reference designators of the affected data elements. A data element may be subject to more than one relational condition. The definitions for each of the condition codes used within syntax notes are detailed below:

CONDITION CODE	DEFINITION
P- Paired or Multiple	If any element specified in the relational condition is present, then all of the elements specified must be present.
R- Required	At least one of the elements specified in the condition must be present.
E- Exclusion	Not more than one of the elements specified in the condition may be present.
C- Conditional	If the first element specified in the condition is present, then all other elements must be present. However, any or all of the elements not specified as the first element in the condition may appear without requiring that the first element be present. The order of the elements in the condition does not have to be the same as the order of the data elements in the data segment.
L- List	

Conditional	If the first element specified in the condition is present, then at least one of the remaining elements must be present. However, any or all of the elements not specified as the first element in the condition may appear without requiring that the first element be present. The order of the elements in the condition does not have to be the same as the order of the data elements in the data segment.

Table A5. Condition Designator

A.1.3.9 Absence of Data

Any simple data element that is indicated as mandatory must not be empty if the segment is used. At least one component data element of a composite data structure that is indicated as mandatory must not be empty if the segment is used. Optional simple data elements and/or composite data structures and their preceding data element separators that are not needed should be omitted if they occur at the end of a segment. If they do not occur at the end of the segment, the simple data element values and/or composite data structure values may be omitted. Their absence is indicated by the occurrence of their preceding data element separators, in order to maintain the element's or structure's position as defined in the data segment.

Likewise, when additional information is not necessary within a composite, the composite may be terminated by providing the appropriate data element separator or segment terminator.

A.1.3.10 Control Segments

A control segment has the same structure as a data segment, but it is used for transferring control information rather than application information.

A.1.3.10.1 Loop Control Segments

Loop control segments are used only to delineate bounded loops. Delineation of the loop shall consist of the loop header (LS segment) and the loop trailer (LE segment). The loop header defines the start of a structure that must contain one or more iterations of a loop of data segments and provides the loop identifier for this loop. The loop trailer defines the end of the structure. The LS segment appears only before the first occurrence of the loop, and the LE segment appears only after the last occurrence of the loop. Unbounded looping structures do not use loop control segments.

A.1.3.10.2 Transaction Set Control Segments

The transaction set is delineated by the transaction set header (ST segment) and the transaction set trailer (SE segment). The transaction set header identifies the start and identifier of the transaction set. The transaction set trailer identifies the end of the transaction set and provides a count of the data segments, which includes the ST and SE segments.

A.1.3.10.3 Functional Group Control Segments

The functional group is delineated by the functional group header (GS segment) and the functional group trailer (GE segment). The functional group header starts and identifies one or more related transaction sets and provides a control number

and application identification information. The functional group trailer defines the end of the functional group of related transaction sets and provides a count of contained transaction sets.

A.1.3.10.4 Relations among Control Segments

The control segment of this standard must have a nested relationship as is shown and annotated in this subsection. The letters preceding the control segment name are the segment identifier for that control segment. The indentation of segment identifiers shown below indicates the subordination among control segments.

GS Functional Group Header, starts a group of related transaction sets.

- **ST** Transaction Set Header, starts a transaction set.
  - **LS** Loop Header, starts a bounded loop of data segments but is not part of the loop.
    - **LS** Loop Header, starts an inner, nested, bounded loop.
    - **LE** Loop Trailer, ends an inner, nested bounded loop.
  - **LE** Loop Trailer, ends a bounded loop of data segments but is not part of the loop.
- **SE** Transaction Set Trailer, ends a transaction set.

GE Functional Group Trailer, ends a group of related transaction sets.

More than one ST/SE pair, each representing a transaction set, may be used within one functional group. Also more than one LS/LE pair, each representing a bounded loop, may be used within one transaction set.

A.1.3.11 Transaction Set

The transaction set is the smallest meaningful set of information exchanged between trading partners. The transaction set consists of a transaction set header segment, one or more data segments in a specified order, and a transaction set trailer segment. See figure A1, Transmission Control Schematic.

A.1.3.11.1 Transaction Set Header and Trailer

A transaction set identifier uniquely identifies a transaction set. This identifier is the first data element of the Transaction Set Header Segment (ST). A user assigned transaction set control number in the header must match the control number in the Trailer Segment (SE) for any given transaction set. The value for the number of included segments in the SE segment is the total number of segments in the transaction set, including the ST and SE segments.

A.1.3.11.2 Data Segment Groups

The data segments in a transaction set may be repeated as individual data segments or as unbounded or bounded loops.

A.1.3.11.3 Repeated Occurrences of Single Data Segments

When a single data segment is allowed to be repeated, it may have a specified maximum number of occurrences defined at each specified position within a given transaction set standard. Alternatively, a segment may be allowed to repeat

an unlimited number of times. The notation for an unlimited number of repetitions is “>1.”

A.1.3.11.4 Loops of Data Segments

Loops are groups of semantically related segments. Data segment loops may be unbounded or bounded.

A.1.3.11.4.1 Unbounded Loops

To establish the iteration of a loop, the first data segment in the loop must appear once and only once in each iteration. Loops may have a specified maximum number of repetitions. Alternatively, the loop may be specified as having an unlimited number of iterations. The notation for an unlimited number of repetitions is “>1.”

A specified sequence of segments is in the loop. Loops themselves are optional or mandatory. The requirement designator of the beginning segment of a loop indicates whether at least one occurrence of the loop is required. Each appearance of the beginning segment defines an occurrence of the loop.

The requirement designator of any segment within the loop after the beginning segment applies to that segment for each occurrence of the loop. If there is a mandatory requirement designator for any data segment within the loop after the beginning segment, that data segment is mandatory for each occurrence of the loop. If the loop is optional, the mandatory segment only occurs if the loop occurs.

A.1.3.11.4.2 Bounded Loops

The characteristics of unbounded loops described previously also apply to bounded loops. In addition, bounded loops require a Loop Start Segment (LS) to appear before the first occurrence and a Loop End Segment (LE) to appear after the last occurrence of the loop. If the loop does not occur, the LS and LE segments are suppressed.

A.1.3.11.5 Data Segments in a Transaction Set

When data segments are combined to form a transaction set, three characteristics are applied to each data segment: a requirement designator, a position in the transaction set, and a maximum occurrence.

A.1.3.11.6 Data Segment Requirement Designators

A data segment, or loop, has one of the following requirement designators for health care and insurance transaction sets, indicating its appearance in the data stream of a transmission. These requirement designators are represented by a single character code.

DESIGNATOR	DESCRIPTION
M- Mandatory	This data segment must be included in the transaction set. (Note that a data segment may be mandatory in a loop of data segments, but the loop itself is optional if the beginning segment of the loop is designated as optional.)
O- Optional	The presence of this data segment is the option of the sending party.

A.1.3.11.7 Data Segment Position

The ordinal positions of the segments in a transaction set are explicitly specified for that transaction. Subject to the flexibility provided by the optional requirement designators of the segments, this positioning must be maintained.

A.1.3.11.8 Data Segment Occurrence

A data segment may have a maximum occurrence of one, a finite number greater than one, or an unlimited number indicated by ">1."

A.1.3.12 Functional Group

A functional group is a group of similar transaction sets that is bounded by a functional group header segment and a functional group trailer segment. The functional identifier defines the group of transactions that may be included within the functional group. The value for the functional group control number in the header and trailer control segments must be identical for any given group. The value for the number of included transaction sets is the total number of transaction sets in the group. See figure A1, Transmission Control Schematic.

A.1.4 Envelopes and Control Structures

A.1.4.1 Interchange Control Structures

Typically, the term "interchange" connotes the ISA/IEA envelope that is transmitted between trading/business partners. Interchange control is achieved through several "control" components. The interchange control number is contained in data element ISA13 of the ISA segment. The identical control number must also occur in data element 02 of the IEA segment. Most commercial translation software products will verify that these two fields are identical. In most translation software products, if these fields are different the interchange will be "suspended" in error.

There are many other features of the ISA segment that are used for control measures. For instance, the ISA segment contains data elements such as authorization information, security information, sender identification, and receiver identification that can be used for control purposes. These data elements are agreed upon by the trading partners prior to transmission and are contained in the written trading partner agreement. The interchange date and time data elements as well as the interchange control number within the ISA segment are used for debugging purposes when there is a problem with the transmission or the interchange.

Data Element ISA12, Interchange Control Version Number, indicates the version of the ISA/IEA envelope. The ISA12 does not indicate the version of the transaction set that is being transmitted but rather the envelope that encapsulates the transaction. An Interchange Acknowledgment can be denoted through data element ISA14. The acknowledgment that would be sent in reply to a "yes" condition in data element ISA14 would be the TA1 segment. Data element ISA15, Test Indicator, is used between trading partners to indicate that the transmission is in a "test" or "production" mode. This becomes significant when the production phase of the project is to commence. Data element ISA16, Subelement Separator, is used by the translator for interpretation of composite data elements.

The ending component of the interchange or ISA/IEA envelope is the IEA segment. Data element IEA01 indicates the number of functional groups that are included within the interchange. In most commercial translation software products, an aggregate count of functional groups is kept while interpreting the interchange. This count is then verified with data element IEA01. If there is a discrep-

ancy, in most commercial products, the interchange is suspended. The other data element in the IEA segment is IEA02 which is referenced above.

See the Appendix B, EDI Control Directory, for a complete detailing of the interchange control header and trailer.

A.1.4.2 Functional Groups

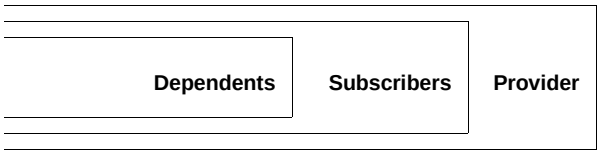
Control structures within the functional group envelope include the functional identifier code in GS01. The Functional Identifier Code is used by the commercial translation software during interpretation of the interchange to determine the different transaction sets that may be included within the functional group. If an inappropriate transaction set is contained within the functional group, most commercial translation software will suspend the functional group within the interchange. The Application Sender's Code in GS02 can be used to identify the sending unit of the transmission. The Application Receiver's Code in GS03 can be used to identify the receiving unit of the transmission. For health care, this unit identification can be used to differentiate between managed care, indemnity, and Medicare. The functional group contains a creation date (GS04) and creation time (GS05) for the functional group. The Group Control Number is contained in GS06. These data elements (GS04, GS05, AND GS06) can be used for debugging purposes during problem resolution. GS08,Version/Release/Industry Identifier Code is the version/release/sub-release of the transaction sets being transmitted in this functional group. Appendix B provides guidance for the value for this data element. The GS08 does not represent the version of the interchange (ISA/IEA) envelope but rather the version/release/sub-release of the transaction sets that are encompassed within the GS/GE envelope.

The Functional Group Control Number in GS06 must be identical to data element 02 of the GE segment. Data element GE01 indicates the number of transaction sets within the functional group. In most commercial translation software products, an aggregate count of the transaction sets is kept while interpreting the functional group. This count is then verified with data element GE01.

See the Appendix B, EDI Control Directory, for a complete detailing of the functional group header and trailer.

A.1.4.3 HL Structures

The HL segment is used in several X12 transaction sets to identify levels of detail information using a hierarchical structure, such as relating dependents to a subscriber. Hierarchical levels may differ from guide to guide. The following diagram, from transaction set 837, illustrates a typical hierarchy.



Each provider can bill for one or more subscribers, each subscriber can have one or more dependents and the subscriber and the dependents can make one or more claims. Each guide states what levels are available, the level's requirement, a repeat value, and whether that level has subordinate levels within a transmission.

A.1.5 Acknowledgments

A.1.5.1 Interchange Acknowledgment, TA1

The Interchange or TA1 Acknowledgment is a means of replying to an interchange or transmission that has been sent. The TA1 verifies the envelopes only. Transaction set-specific verification is accomplished through use of the Functional Acknowledgment Transaction Set, 997. See A.1.5.2, Functional Acknowledgment, 997, for more details. The TA1 is a single segment and is unique in the sense that this single segment is transmitted without the GS/GE envelope structures. A TA1 can be included in an interchange with other functional groups and transactions.

Encompassed in the TA1 are the interchange control number, interchange date and time, interchange acknowledgment code, and the interchange note code. The interchange control number, interchange date and time are identical to those that were present in the transmitted interchange from the sending trading partner. This provides the capability to associate the TA1 with the transmitted interchange. TA104, Interchange Acknowledgment Code, indicates the status of the interchange control structure. This data element stipulates whether the transmitted interchange was accepted with no errors, accepted with errors, or rejected because of errors. TA105, Interchange Note Code, is a numerical code that indicates the error found while processing the interchange control structure. Values for this data element indicate whether the error occurred at the interchange or functional group envelope.

The TA1 segment provides the capability for the receiving trading partner to notify the sending trading partner of problems that were encountered in the interchange control structure.

Due to the uniqueness of the TA1, implementation should be predicated upon the ability for the sending and receiving trading partners commercial translators to accommodate the uniqueness of the TA1. Unless named as mandatory in the Federal Rules implementing HIPAA, use of the TA1, although urged by the authors, is not mandated.

See the Appendix B, EDI Control Directory, for a complete detailing of the TA1 segment.

A.1.5.2 Functional Acknowledgment, 997

The Functional Acknowledgment Transaction Set, 997, has been designed to allow trading partners to establish a comprehensive control function as a part of their business exchange process. This acknowledgment process facilitates control of EDI. There is a one-to-one correspondence between a 997 and a functional group. Segments within the 997 can identify the acceptance or rejection of the functional group, transaction sets or segments. Data elements in error can also be identified. There are many EDI implementations that have incorporated the acknowledgment process in all of their electronic communications. Typically, the 997 is used as a functional acknowledgment to a previously transmitted functional group. Many commercially available translators can automatically generate this transaction set through internal parameter settings. Additionally translators will automatically reconcile received acknowledgments to functional groups that have been sent. The benefit to this process is that the sending trading partner

can determine if the receiving trading partner has received ASC X12 transaction sets through reports that can be generated by the translation software to identify transmissions that have not been acknowledged.

As stated previously the 997 is a transaction set and thus is encapsulated within the interchange control structure (envelopes) for transmission.

As with any information flow, an acknowledgment process is essential. If an “automatic” acknowledgment process is desired between trading partners then it is recommended that the 997 be used. Unless named as mandatory in the Federal Rules implementing HIPAA, use of the 997, although recommended by the authors, is not mandated.

See Appendix B, EDI Control Directory, for a complete detailing of transaction set 997.

B EDI Control Directory

B.1 Control Segments

- **ISA**
  Interchange Control Header Segment
- **IEA**
  Interchange Control Trailer Segment
- **GS**
  Functional Group Header Segment
- **GE**
  Functional Group Trailer Segment
- **TA1**
  Interchange Acknowledgment Segment

B.2 Functional Acknowledgment Transaction Set, 997

IMPLEMENTATION

INTERCHANGE CONTROL HEADER

Notes: **1. The ISA is a fixed record length segment and all positions within each of the data elements must be filled. The first element separator defines the element separator to be used through the entire interchange. The segment terminator used after the ISA defines the segment terminator to be used throughout the entire interchange. Spaces in the example are represented by "." for clarity.**

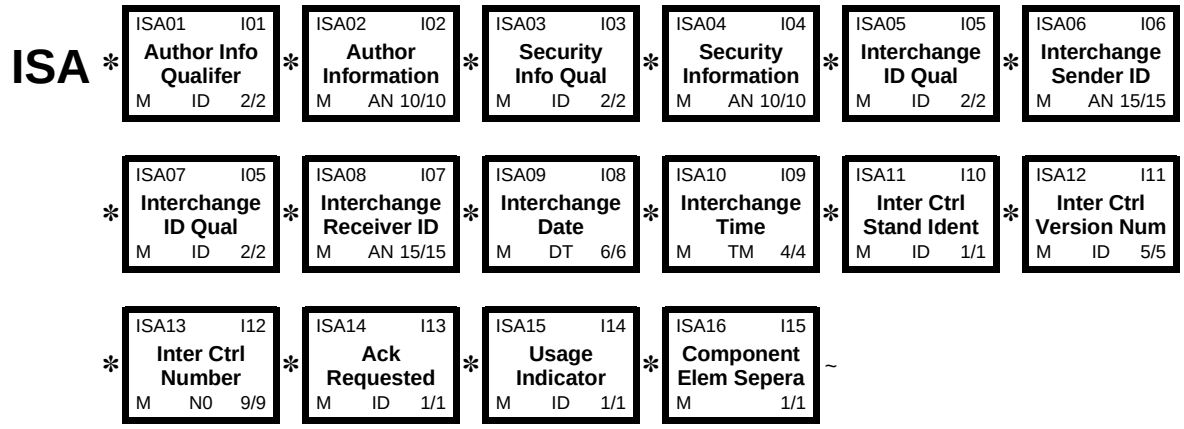
Example: **ISA* 00* .....* 01* SECRET....* ZZ* SUBMITTERS.ID..* ZZ* RECEIVERS.ID...* 930602* 1253* U* 00401* 000000905* 1* T* :~**

STANDARD

ISA Interchange Control Header

Purpose: To start and identify an interchange of zero or more functional groups and interchange-related control segments

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**ISA01**	**I01**	**Authorization Information Qualifier** Code to identify the type of information in the Authorization Information	**M ID 2/2**
			CODE / **DEFINITION** **00** — **No Authorization Information Present (No Meaningful Information in I02)** **ADVISED UNLESS SECURITY REQUIREMENTS MANDATE USE OF ADDITIONAL IDENTIFICATION INFORMATION.** **03** — **Additional Data Identification**	
REQUIRED	**ISA02**	**I02**	**Authorization Information** Information used for additional identification or authorization of the interchange sender or the data in the interchange; the type of information is set by the Authorization Information Qualifier (I01)	**M AN 10/10**

REQUIRED **ISA03** **I03** **Security Information Qualifier** **M ID 2/2**
Code to identify the type of information in the Security Information

CODE	DEFINITION
00	**No Security Information Present (No Meaningful Information in I04)** **ADVISED UNLESS SECURITY REQUIREMENTS MANDATE USE OF PASSWORD DATA.**
01	**Password**

REQUIRED **ISA04** **I04** **Security Information** **M AN 10/10**
This is used for identifying the security information about the interchange sender or the data in the interchange; the type of information is set by the Security Information Qualifier (I03)

REQUIRED **ISA05** **I05** **Interchange ID Qualifier** **M ID 2/2**
Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified

This ID qualifies the Sender in ISA06.

CODE	DEFINITION
01	**Duns (Dun & Bradstreet)**
14	**Duns Plus Suffix**
20	**Health Industry Number (HIN)** CODE SOURCE **121: Health Industry Identification Number**
27	**Carrier Identification Number as assigned by Health Care Financing Administration (HCFA)**
28	**Fiscal Intermediary Identification Number as assigned by Health Care Financing Administration (HCFA)**
29	**Medicare Provider and Supplier Identification Number as assigned by Health Care Financing Administration (HCFA)**
30	**U.S. Federal Tax Identification Number**
33	**National Association of Insurance Commissioners Company Code (NAIC)**
ZZ	**Mutually Defined**

REQUIRED **ISA06** **I06** **Interchange Sender ID** **M AN 15/15**
Identification code published by the sender for other parties to use as the receiver ID to route data to them; the sender always codes this value in the sender ID element

REQUIRED **ISA07** **I05** **Interchange ID Qualifier** **M ID 2/2**
Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified

This ID qualifies the Receiver in ISA08.

CODE	DEFINITION
01	**Duns (Dun & Bradstreet)**

			14	**Duns Plus Suffix**		
			20	**Health Industry Number (HIN)**		
				CODE SOURCE **121: Health Industry Identification Number**		
			27	**Carrier Identification Number as assigned by Health Care Financing Administration (HCFA)**		
			28	**Fiscal Intermediary Identification Number as assigned by Health Care Financing Administration (HCFA)**		
			29	**Medicare Provider and Supplier Identification Number as assigned by Health Care Financing Administration (HCFA)**		
			30	**U.S. Federal Tax Identification Number**		
			33	**National Association of Insurance Commissioners Company Code (NAIC)**		
			ZZ	**Mutually Defined**		
REQUIRED	**ISA08**	**I07**	**Interchange Receiver ID**		**M**	**AN**	**15/15**
			Identification code published by the receiver of the data; When sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them				
REQUIRED	**ISA09**	**I08**	**Interchange Date**		**M**	**DT**	**6/6**
			Date of the interchange				
			The date format is YYMMDD.				
REQUIRED	**ISA10**	**I09**	**Interchange Time**		**M**	**TM**	**4/4**
			Time of the interchange				
			The time format is HHMM.				
REQUIRED	**ISA11**	**I10**	**Interchange Control Standards Identifier**		**M**	**ID**	**1/1**
			Code to identify the agency responsible for the control standard used by the message that is enclosed by the interchange header and trailer				
			CODE	DEFINITION			
			U	**U.S. EDI Community of ASC X12, TDCC, and UCS**			
REQUIRED	**ISA12**	**I11**	**Interchange Control Version Number**		**M**	**ID**	**5/5**
			This version number covers the interchange control segments				
			CODE	DEFINITION			
			00401	**Draft Standards for Trial Use Approved for Publication by ASC X12 Procedures Review Board through October 1997**			
REQUIRED	**ISA13**	**I12**	**Interchange Control Number**		**M**	**N0**	**9/9**
			A control number assigned by the interchange sender				
			The Interchange Control Number, ISA13, must be identical to the associated Interchange Trailer IEA02.				

REQUIRED **ISA14** **I13** **Acknowledgment Requested** **M** **ID** **1/1**
Code sent by the sender to request an interchange acknowledgment (TA1)

See Section A.1.5.1 for interchange acknowledgment information.

CODE	DEFINITION
0	**No Acknowledgment Requested**
1	**Interchange Acknowledgment Requested**

REQUIRED **ISA15** **I14** **Usage Indicator** **M** **ID** **1/1**
Code to indicate whether data enclosed by this interchange envelope is test, production or information

CODE	DEFINITION
P	**Production Data**
T	**Test Data**

REQUIRED **ISA16** **I15** **Component Element Separator** **M** **1/1**
Type is not applicable; the component element separator is a delimiter and not a data element; this field provides the delimiter used to separate component data elements within a composite data structure; this value must be different than the data element separator and the segment terminator

IMPLEMENTATION

INTERCHANGE CONTROL TRAILER

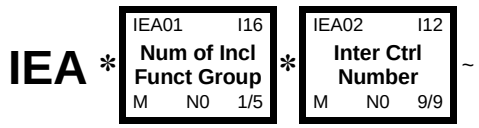
Example: IEA*1*000000905~

STANDARD

IEA Interchange Control Trailer

Purpose: To define the end of an interchange of zero or more functional groups and interchange-related control segments

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**IEA01**	**I16**	**Number of Included Functional Groups** A count of the number of functional groups included in an interchange	**M**	**N0**	**1/5**
REQUIRED	**IEA02**	**I12**	**Interchange Control Number** A control number assigned by the interchange sender	**M**	**N0**	**9/9**

IMPLEMENTATION

FUNCTIONAL GROUP HEADER

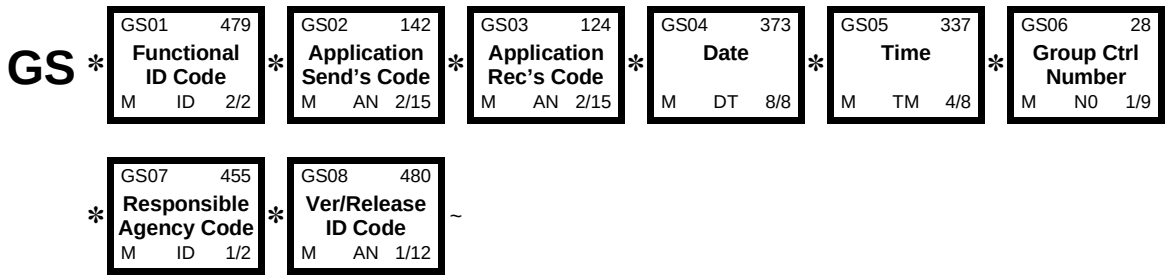
Example: GS*HB*SENDER CODE*RECEIVER CODE*19971001*0802*1*X*004010X092~

STANDARD

GS Functional Group Header

Purpose: To indicate the beginning of a functional group and to provide control information

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**GS01**	**479**	**Functional Identifier Code** Code identifying a group of application related transaction sets	**M ID 2/2**
			CODE / DEFINITION	
			HB **Eligibility, Coverage or Benefit Information (271)**	
			HS **Eligibility, Coverage or Benefit Inquiry (270)**	
REQUIRED	**GS02**	**142**	**Application Sender's Code** Code identifying party sending transmission; codes agreed to by trading partners	**M AN 2/15**
			Use this code to identify the unit sending the information.	
REQUIRED	**GS03**	**124**	**Application Receiver's Code** Code identifying party receiving transmission. Codes agreed to by trading partners	**M AN 2/15**
			Use this code to identify the unit receiving the information.	
REQUIRED	**GS04**	**373**	**Date** Date expressed as CCYYMMDD **SEMANTIC:** GS04 is the group date.	**M DT 8/8**
			Use this date for the functional group creation date.	

REQUIRED	**GS05**	**337**	**Time**	**M**	**TM**	**4/8**

Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99)

SEMANTIC: GS05 is the group time.

Use this time for the creation time. The recommended format is HHMM.

REQUIRED	**GS06**	**28**	**Group Control Number**	**M**	**N0**	**1/9**

Assigned number originated and maintained by the sender

SEMANTIC: The data interchange control number GS06 in this header must be identical to the same data element in the associated functional group trailer, GE02.

REQUIRED	**GS07**	**455**	**Responsible Agency Code**	**M**	**ID**	**1/2**

Code used in conjunction with Data Element 480 to identify the issuer of the standard

CODE	DEFINITION
X	**Accredited Standards Committee X12**

REQUIRED	**GS08**	**480**	**Version / Release / Industry Identifier Code**	**M**	**AN**	**1/12**

Code indicating the version, release, subrelease, and industry identifier of the EDI standard being used, including the GS and GE segments; if code in DE455 in GS segment is X, then in DE 480 positions 1-3 are the version number; positions 4-6 are the release and subrelease, level of the version; and positions 7-12 are the industry or trade association identifiers (optionally assigned by user); if code in DE455 in GS segment is T, then other formats are allowed

CODE	DEFINITION
004010X092	**Draft Standards Approved for Publication by ASC X12 Procedures Review Board through October 1997, as published in this implementation guide.**

IMPLEMENTATION

FUNCTIONAL GROUP TRAILER

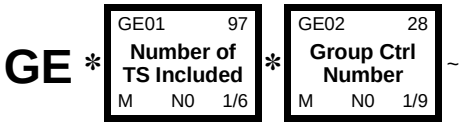
Example: **GE*1*1~**

STANDARD

GE Functional Group Trailer

Purpose: To indicate the end of a functional group and to provide control information

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**GE01**	**97**	**Number of Transaction Sets Included** Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element	**M**	**N0**	**1/6**
REQUIRED	**GE02**	**28**	**Group Control Number** Assigned number originated and maintained by the sender **SEMANTIC:** The data interchange control number GE02 in this trailer must be identical to the same data element in the associated functional group header, GS06.	**M**	**N0**	**1/9**

IMPLEMENTATION

INTERCHANGE ACKNOWLEDGMENT

Notes:

1. **All fields must contain data.**
2. **This segment acknowledges the reception of an X12 interchange header and trailer from a previous interchange. If the header/trailer pair was received correctly, the TA1 reflects a valid interchange, regardless of the validity of the contents of the data included inside the header/trailer envelope.**
3. **See Section A.1.5.1 for interchange acknowledgment information.**
4. **Use of TA1 is subject to trading partner agreement and is neither mandated or prohibited in this Appendix.**

Example: **TA1*000000905*940101*0100*A*000~**

STANDARD

TA1 Interchange Acknowledgment

Purpose: To report the status of processing a received interchange header and trailer or the non-delivery by a network provider

DIAGRAM

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**TA101**	**I12**	**Interchange Control Number** A control number assigned by the interchange sender	**M N0 9/9**
			This number uniquely identifies the interchange data to the sender. It is assigned by the sender. Together with the sender ID it uniquely identifies the interchange data to the receiver. It is suggested that the sender, receiver, and all third parties be able to maintain an audit trail of interchanges using this number.	
			In the TA1, this should be the interchange control number of the original interchange that this TA1 is acknowledging.	
REQUIRED	**TA102**	**I08**	**Interchange Date** Date of the interchange	**M DT 6/6**
			This is the date of the original interchange being acknowledged. (YYMMDD)	
REQUIRED	**TA103**	**I09**	**Interchange Time** Time of the interchange	**M TM 4/4**
			This is the time of the original interchange being acknowledged. (HHMM)	

REQUIRED **TA104** **I17** **Interchange Acknowledgment Code** **M ID 1/1**

This indicates the status of the receipt of the interchange control structure

CODE	DEFINITION
A	The Transmitted Interchange Control Structure Header and Trailer Have Been Received and Have No Errors.
E	The Transmitted Interchange Control Structure Header and Trailer Have Been Received and Are Accepted But Errors Are Noted. This Means the Sender Must Not Resend This Data.
R	The Transmitted Interchange Control Structure Header and Trailer are Rejected Because of Errors.

REQUIRED **TA105** **I18** **Interchange Note Code** **M ID 3/3**

This numeric code indicates the error found processing the interchange control structure

CODE	DEFINITION
000	No error
001	The Interchange Control Number in the Header and Trailer Do Not Match. The Value From the Header is Used in the Acknowledgment.
002	This Standard as Noted in the Control Standards Identifier is Not Supported.
003	This Version of the Controls is Not Supported
004	The Segment Terminator is Invalid
005	Invalid Interchange ID Qualifier for Sender
006	Invalid Interchange Sender ID
007	Invalid Interchange ID Qualifier for Receiver
008	Invalid Interchange Receiver ID
009	Unknown Interchange Receiver ID
010	Invalid Authorization Information Qualifier Value
011	Invalid Authorization Information Value
012	Invalid Security Information Qualifier Value
013	Invalid Security Information Value
014	Invalid Interchange Date Value
015	Invalid Interchange Time Value
016	Invalid Interchange Standards Identifier Value
017	Invalid Interchange Version ID Value
018	Invalid Interchange Control Number Value

019	Invalid Acknowledgment Requested Value
020	Invalid Test Indicator Value
021	Invalid Number of Included Groups Value
022	Invalid Control Structure
023	Improper (Premature) End-of-File (Transmission)
024	Invalid Interchange Content (e.g., Invalid GS Segment)
025	Duplicate Interchange Control Number
026	Invalid Data Element Separator
027	Invalid Component Element Separator
028	Invalid Delivery Date in Deferred Delivery Request
029	Invalid Delivery Time in Deferred Delivery Request
030	Invalid Delivery Time Code in Deferred Delivery Request
031	Invalid Grade of Service Code

STANDARD

997 Functional Acknowledgment

Functional Group ID: FA

This Draft Standard for Trial Use contains the format and establishes the data contents of the Functional Acknowledgment Transaction Set (997) for use within the context of an Electronic Data Interchange (EDI) environment. The transaction set can be used to define the control structures for a set of acknowledgments to indicate the results of the syntactical analysis of the electronically encoded documents. The encoded documents are the transaction sets, which are grouped in functional groups, used in defining transactions for business data interchange. This standard does not cover the semantic meaning of the information encoded in the transaction sets.

Table 1 - Header

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
010	ST	Transaction Set Header	M	1	
020	AK1	Functional Group Response Header	M	1	
		LOOP ID - AK2			999999
030	AK2	Transaction Set Response Header	O	1	
		LOOP ID - AK2/AK3			999999
040	AK3	Data Segment Note	O	1	
050	AK4	Data Element Note	O	99	
060	AK5	Transaction Set Response Trailer	M	1	
070	AK9	Functional Group Response Trailer	M	1	
080	SE	Transaction Set Trailer	M	1	

NOTES:

1/010 These acknowledgments shall not be acknowledged, thereby preventing an endless cycle of acknowledgments of acknowledgments. Nor shall a Functional Acknowledgment be sent to report errors in a previous Functional Acknowledgment.

1/010 The Functional Group Header Segment (GS) is used to start the envelope for the Functional Acknowledgment Transaction Sets. In preparing the functional group of acknowledgments, the application sender's code and the application receiver's code, taken from the functional group being acknowledged, are exchanged; therefore, one acknowledgment functional group responds to only those functional groups from one application receiver's code to one application sender's code.

1/010 There is only one Functional Acknowledgment Transaction Set per acknowledged functional group.

1/020 AK1 is used to respond to the functional group header and to start the acknowledgement for a functional group. There shall be one AK1 segment for the functional group that is being acknowledged.

1/030 AK2 is used to start the acknowledgement of a transaction set within the received functional group. The AK2 segments shall appear in the same order as the transaction sets in the functional group that has been received and is being acknowledged.

1/040 The data segments of this standard are used to report the results of the syntactical analysis of the functional groups of transaction sets; they report the extent to which the syntax complies with the standards for transaction sets and functional groups. They do not report on the semantic meaning of the transaction sets (for example, on the ability of the receiver to comply with the request of the sender).

IMPLEMENTATION

TRANSACTION SET HEADER

Usage: **REQUIRED**

Repeat: **1**

Notes:
1. **Use of the 997 transaction is subject to trading partner agreement or accepted usage and is neither mandated nor prohibited in this Appendix.**

Example: **ST*997*1234~**

STANDARD

ST Transaction Set Header

Level: Header

Position: 010

Loop: ____

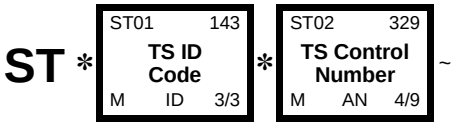
Requirement: Mandatory

Max Use: 1

Purpose: To indicate the start of a transaction set and to assign a control number

Set Notes:
1. These acknowledgments shall not be acknowledged, thereby preventing an endless cycle of acknowledgments of acknowledgments. Nor shall a Functional Acknowledgment be sent to report errors in a previous Functional Acknowledgment.
2. The Functional Group Header Segment (GS) is used to start the envelope for the Functional Acknowledgment Transaction Sets. In preparing the functional group of acknowledgments, the application sender's code and the application receiver's code, taken from the functional group being acknowledged, are exchanged; therefore, one acknowledgment functional group responds to only those functional groups from one application receiver's code to one application sender's code.
3. There is only one Functional Acknowledgment Transaction Set per acknowledged functional group.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**ST01**	**143**	**Transaction Set Identifier Code** Code uniquely identifying a Transaction Set **SEMANTIC:** The transaction set identifier (ST01) used by the translation routines of the interchange partners to select the appropriate transaction set definition (e.g., 810 selects the Invoice Transaction Set). **CODE** **DEFINITION** **997** **Functional Acknowledgment**	**M ID 3/3**
REQUIRED	**ST02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set **The Transaction Set Control Numbers in ST02 and SE02 must be identical. The number is assigned by the originator and must be unique within a functional group (GS-GE). The number also aids in error resolution research. For example, start with the number 0001 and increment from there.** **Use the corresponding value in SE02 for this transaction set.**	**M AN 4/9**

IMPLEMENTATION

FUNCTIONAL GROUP RESPONSE HEADER

Usage: **REQUIRED**

Repeat: **1**

Example: **AK1*HB*1~**

STANDARD

AK1 Functional Group Response Header

Level: Header

Position: 020

Loop: ____

Requirement: Mandatory

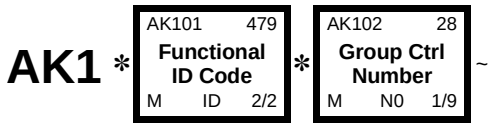
Max Use: 1

Purpose: To start acknowledgment of a functional group

Set Notes:

1. AK1 is used to respond to the functional group header and to start the acknowledgement for a functional group. There shall be one AK1 segment for the functional group that is being acknowledged.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AK101**	**479**	**Functional Identifier Code** Code identifying a group of application related transaction sets **SEMANTIC:** AK101 is the functional ID found in the GS segment (GS01) in the functional group being acknowledged.	**M ID 2/2**
			CODE / **DEFINITION** **HB** — **Eligibility, Coverage or Benefit Information (271)** **HS** — **Eligibility, Coverage or Benefit Inquiry (270)**	
REQUIRED	**AK102**	**28**	**Group Control Number** Assigned number originated and maintained by the sender **SEMANTIC:** AK102 is the functional group control number found in the GS segment in the functional group being acknowledged.	**M N0 1/9**

IMPLEMENTATION

TRANSACTION SET RESPONSE HEADER

Loop: **AK2 — TRANSACTION SET RESPONSE HEADER Repeat: 999999**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required when communicating information about a transaction set within the functional group identified in AK1.**

Example: **AK2*270*000000905~**

STANDARD

AK2 Transaction Set Response Header

Level: Header

Position: 030

Loop: AK2 **Repeat:** 999999

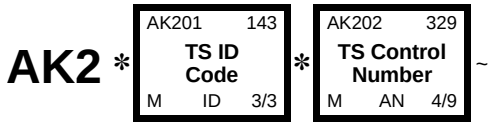
Requirement: Optional

Max Use: 1

Purpose: To start acknowledgment of a single transaction set

Set Notes: **1.** AK2 is used to start the acknowledgement of a transaction set within the received functional group. The AK2 segments shall appear in the same order as the transaction sets in the functional group that has been received and is being acknowledged.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AK201**	**143**	**Transaction Set Identifier Code** Code uniquely identifying a Transaction Set **SEMANTIC:** AK201 is the transaction set ID found in the ST segment (ST01) in the transaction set being acknowledged.	**M ID 3/3**
			CODE / **DEFINITION** **270** **Eligibility, Coverage or Benefit Inquiry** **271** **Eligibility, Coverage or Benefit Information**	
REQUIRED	**AK202**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set **SEMANTIC:** AK202 is the transaction set control number found in the ST segment in the transaction set being acknowledged.	**M AN 4/9**

IMPLEMENTATION

DATA SEGMENT NOTE

Loop: **AK2/AK3 — DATA SEGMENT NOTE** **Repeat:** **999999**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Used when there are errors to report in a transaction.**

Example: **AK3*NM1*37*2010BB*7~**

STANDARD

AK3 Data Segment Note

Level: Header

Position: 040

Loop: AK2/AK3 **Repeat:** 999999

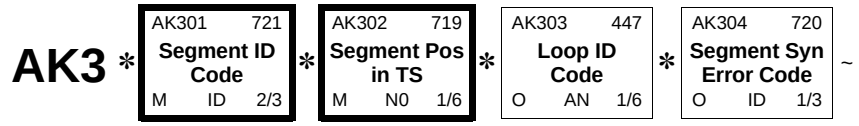
Requirement: Optional

Max Use: 1

Purpose: To report errors in a data segment and identify the location of the data segment

Set Notes: **1.** The data segments of this standard are used to report the results of the syntactical analysis of the functional groups of transaction sets; they report the extent to which the syntax complies with the standards for transaction sets and functional groups. They do not report on the semantic meaning of the transaction sets (for example, on the ability of the receiver to comply with the request of the sender).

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AK301**	**721**	**Segment ID Code** Code defining the segment ID of the data segment in error (See Appendix A - Number 77) **CODE SOURCE 77:** X12 Directories **This is the 2 or 3 characters which occur at the beginning of a segment.**	**M ID 2/3**
REQUIRED	**AK302**	**719**	**Segment Position in Transaction Set** The numerical count position of this data segment from the start of the transaction set: the transaction set header is count position 1 **This is a data count, not a segment position in the standard description.**	**M N0 1/6**

SITUATIONAL **AK303** **447** **Loop Identifier Code** **O AN 1/6**
The loop ID number given on the transaction set diagram is the value for this data element in segments LS and LE

Use this code to identify a loop within the transaction set that is bounded by the related LS and LE segments (corresponding LS and LE segments must have the same value for loop identifier). (Note: The loop ID number given on the transaction set diagram is recommended as the value for this data element in the segments LS and LE.)

SITUATIONAL **AK304** **720** **Segment Syntax Error Code** **O ID 1/3**
Code indicating error found based on the syntax editing of a segment

This code is required if an error exists.

CODE	DEFINITION
1	Unrecognized segment ID
2	Unexpected segment
3	Mandatory segment missing
4	Loop Occurs Over Maximum Times
5	Segment Exceeds Maximum Use
6	Segment Not in Defined Transaction Set
7	Segment Not in Proper Sequence
8	Segment Has Data Element Errors

IMPLEMENTATION

DATA ELEMENT NOTE

Loop: **AK2/AK3 — DATA SEGMENT NOTE**

Usage: **SITUATIONAL**

Repeat: **99**

Notes: **1. Used when there are errors to report in a data element or composite data structure.**

Example: **AK4*1*98*7~**

STANDARD

AK4 Data Element Note

Level: Header

Position: 050

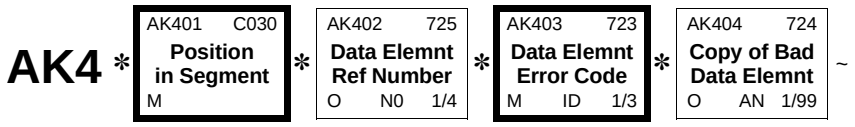
Loop: AK2/AK3

Requirement: Optional

Max Use: 99

Purpose: To report errors in a data element or composite data structure and identify the location of the data element

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AK401**	**C030**	**POSITION IN SEGMENT** Code indicating the relative position of a simple data element, or the relative position of a composite data structure combined with the relative position of the component data element within the composite data structure, in error; the count starts with 1 for the simple data element or composite data structure immediately following the segment ID	**M**
REQUIRED	**AK401 - 1**	**722**	**Element Position in Segment** This is used to indicate the relative position of a simple data element, or the relative position of a composite data structure with the relative position of the component within the composite data structure, in error; in the data segment the count starts with 1 for the simple data element or composite data structure immediately following the segment ID	**M N0 1/2**
SITUATIONAL	**AK401 - 2**	**1528**	**Component Data Element Position in Composite** To identify the component data element position within the composite that is in error	**O N0 1/2**
			Used when an error occurs in a composite data element and the composite data element position can be determined.	

SITUATIONAL **AK402** **725** **Data Element Reference Number** **O** **N0** **1/4**
Reference number used to locate the data element in the Data Element Dictionary

ADVISORY: Under most circumstances, this element is expected to be sent.

CODE SOURCE 77: X12 Directories

The Data Element Reference Number for this data element is 725. For example, all reference numbers are found with the segment descriptions in this guide.

REQUIRED **AK403** **723** **Data Element Syntax Error Code** **M** **ID** **1/3**
Code indicating the error found after syntax edits of a data element

CODE	DEFINITION
1	Mandatory data element missing
2	Conditional required data element missing.
3	Too many data elements.
4	Data element too short.
5	Data element too long.
6	Invalid character in data element.
7	Invalid code value.
8	Invalid Date
9	Invalid Time
10	Exclusion Condition Violated

SITUATIONAL **AK404** **724** **Copy of Bad Data Element** **O** **AN** **1/99**
This is a copy of the data element in error

SEMANTIC: In no case shall a value be used for AK404 that would generate a syntax error, e.g., an invalid character.

Used to provide copy of erroneous data to the original submitter, but this is not used if the error reported in an invalid character.

IMPLEMENTATION

TRANSACTION SET RESPONSE TRAILER

Loop: **AK2/AK3 — DATA SEGMENT NOTE**

Usage: **REQUIRED**

Repeat: **1**

Example: **AK5*E*5~**

STANDARD

AK5 Transaction Set Response Trailer

Level: Header

Position: 060

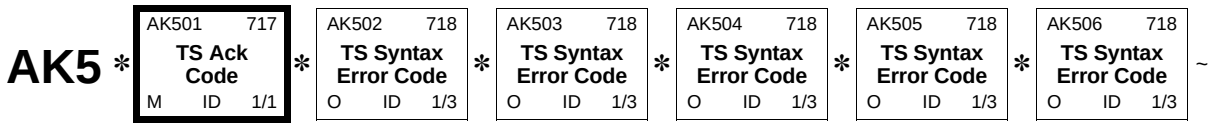
Loop: AK2

Requirement: Mandatory

Max Use: 1

Purpose: To acknowledge acceptance or rejection and report errors in a transaction set

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AK501**	**717**	**Transaction Set Acknowledgment Code** Code indicating accept or reject condition based on the syntax editing of the transaction set	**M ID 1/1**

CODE	DEFINITION
A	**Accepted** **ADVISED**
E	**Accepted But Errors Were Noted**
M	**Rejected, Message Authentication Code (MAC) Failed**
R	**Rejected** **ADVISED**
W	**Rejected, Assurance Failed Validity Tests**
X	**Rejected, Content After Decryption Could Not Be Analyzed**

SITUATIONAL **AK502** **718** **Transaction Set Syntax Error Code** **O ID 1/3**
Code indicating error found based on the syntax editing of a transaction set

This code is required if an error exists.

CODE	DEFINITION
1	Transaction Set Not Supported
2	Transaction Set Trailer Missing
3	Transaction Set Control Number in Header and Trailer Do Not Match
4	Number of Included Segments Does Not Match Actual Count
5	One or More Segments in Error
6	Missing or Invalid Transaction Set Identifier
7	Missing or Invalid Transaction Set Control Number
8	Authentication Key Name Unknown
9	Encryption Key Name Unknown
10	Requested Service (Authentication or Encrypted) Not Available
11	Unknown Security Recipient
12	Incorrect Message Length (Encryption Only)
13	Message Authentication Code Failed
15	Unknown Security Originator
16	Syntax Error in Decrypted Text
17	Security Not Supported
23	Transaction Set Control Number Not Unique within the Functional Group
24	S3E Security End Segment Missing for S3S Security Start Segment
25	S3S Security Start Segment Missing for S3E Security End Segment
26	S4E Security End Segment Missing for S4S Security Start Segment
27	S4S Security Start Segment Missing for S4E Security End Segment

SITUATIONAL **AK503** **718** **Transaction Set Syntax Error Code** **O ID 1/3**
Code indicating error found based on the syntax editing of a transaction set

Use the same codes indicated in AK502.

SITUATIONAL	**AK504**	**718**	**Transaction Set Syntax Error Code** Code indicating error found based on the syntax editing of a transaction set	**O**	**ID**	**1/3**
			Use the same codes indicated in AK502.			
SITUATIONAL	**AK505**	**718**	**Transaction Set Syntax Error Code** Code indicating error found based on the syntax editing of a transaction set	**O**	**ID**	**1/3**
			Use the same codes indicated in AK502.			
SITUATIONAL	**AK506**	**718**	**Transaction Set Syntax Error Code** Code indicating error found based on the syntax editing of a transaction set	**O**	**ID**	**1/3**
			Use the same codes indicated in AK502.			

IMPLEMENTATION

FUNCTIONAL GROUP RESPONSE TRAILER

Usage: **REQUIRED**

Repeat: **1**

Example: **AK9*A*1*1*1~**

STANDARD

AK9 Functional Group Response Trailer

Level: Header

Position: 070

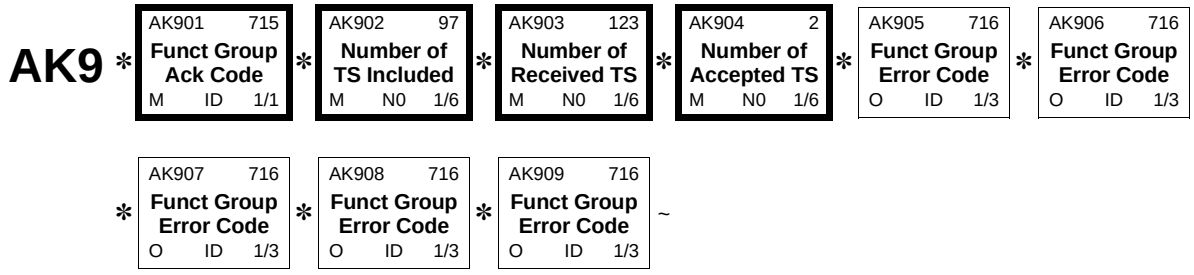
Loop: ____

Requirement: Mandatory

Max Use: 1

Purpose: To acknowledge acceptance or rejection of a functional group and report the number of included transaction sets from the original trailer, the accepted sets, and the received sets in this functional group

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AK901**	**715**	**Functional Group Acknowledge Code** Code indicating accept or reject condition based on the syntax editing of the functional group COMMENT: If AK901 contains the value “A” or “E”, then the transmitted functional group is accepted.	**M ID 1/1**

CODE	DEFINITION
A	**Accepted** **ADVISED**
E	**Accepted, But Errors Were Noted.**
M	**Rejected, Message Authentication Code (MAC) Failed**

			P	**Partially Accepted, At Least One Transaction Set Was Rejected** **ADVISED**			
			R	**Rejected** **ADVISED**			
			W	**Rejected, Assurance Failed Validity Tests**			
			X	**Rejected, Content After Decryption Could Not Be Analyzed**			
REQUIRED	**AK902**	**97**	**Number of Transaction Sets Included** Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element	**M**	**N0**	**1/6**	
			This is the value in the original GE01.				
REQUIRED	**AK903**	**123**	**Number of Received Transaction Sets** Number of Transaction Sets received	**M**	**N0**	**1/6**	
REQUIRED	**AK904**	**2**	**Number of Accepted Transaction Sets** Number of accepted Transaction Sets in a Functional Group	**M**	**N0**	**1/6**	
SITUATIONAL	**AK905**	**716**	**Functional Group Syntax Error Code** Code indicating error found based on the syntax editing of the functional group header and/or trailer	**O**	**ID**	**1/3**	
			This code is required if an error exists.				

CODE	DEFINITION
1	**Functional Group Not Supported**
2	**Functional Group Version Not Supported**
3	**Functional Group Trailer Missing**
4	**Group Control Number in the Functional Group Header and Trailer Do Not Agree**
5	**Number of Included Transaction Sets Does Not Match Actual Count**
6	**Group Control Number Violates Syntax**
10	**Authentication Key Name Unknown**
11	**Encryption Key Name Unknown**
12	**Requested Service (Authentication or Encryption) Not Available**
13	**Unknown Security Recipient**
14	**Unknown Security Originator**
15	**Syntax Error in Decrypted Text**
16	**Security Not Supported**
17	**Incorrect Message Length (Encryption Only)**
18	**Message Authentication Code Failed**

			23	**S3E Security End Segment Missing for S3S Security Start Segment**			
			24	**S3S Security Start Segment Missing for S3E End Segment**			
			25	**S4E Security End Segment Missing for S4S Security Start Segment**			
			26	**S4S Security Start Segment Missing for S4E Security End Segment**			
SITUATIONAL	**AK906**	**716**	**Functional Group Syntax Error Code** Code indicating error found based on the syntax editing of the functional group header and/or trailer	**O**	**ID**	**1/3**	
			Use the same codes indicated in AK905.				
SITUATIONAL	**AK907**	**716**	**Functional Group Syntax Error Code** Code indicating error found based on the syntax editing of the functional group header and/or trailer	**O**	**ID**	**1/3**	
			Use the same codes indicated in AK905.				
SITUATIONAL	**AK908**	**716**	**Functional Group Syntax Error Code** Code indicating error found based on the syntax editing of the functional group header and/or trailer	**O**	**ID**	**1/3**	
			Use the same codes indicated in AK905.				
SITUATIONAL	**AK909**	**716**	**Functional Group Syntax Error Code** Code indicating error found based on the syntax editing of the functional group header and/or trailer	**O**	**ID**	**1/3**	
			Use the same codes indicated in AK905.				

IMPLEMENTATION

TRANSACTION SET TRAILER

Usage: **REQUIRED**

Repeat: **1**

Example: **SE*27*1234~**

STANDARD

SE Transaction Set Trailer

Level: Header

Position: 080

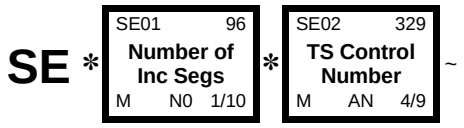
Loop: ____

Requirement: Mandatory

Max Use: 1

Purpose: To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning (ST) and ending (SE) segments)

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**SE01**	**96**	**Number of Included Segments** Total number of segments included in a transaction set including ST and SE segments	**M N0 1/10**
REQUIRED	**SE02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set	**M AN 4/9**
			The Transaction Set Control Numbers in ST02 and SE02 must be identical. The number is assigned by the originator and must be unique within a functional group (GS-GE). The number also aids in error resolution research. For example, start with the number 0001 and increment from there.	

C External Code Sources

5 Countries, Currencies and Funds

SIMPLE DATA ELEMENT/CODE REFERENCES

235/CH, 26, 100

SOURCE

Codes for Representation of Names of Countries, ISO 3166-(Latest Release)
Codes for Representation of Currencies and Funds, ISO 4217-(Latest Release)

AVAILABLE FROM

American National Standards Institute
11 West 42nd Street, 13th Floor
New York, NY 10036

ABSTRACT

This international standard provides a two-letter alphabetic code for representing the names of countries, dependencies, and other areas of special geopolitical interest for purposes of international exchange and general directions for the maintenance of the code. The standard is intended for use in any application requiring expression of entitles in coded form. Most currencies are those of the geopolitical entities that are listed in ISO 3166, Codes for the Representation of Names of Countries. The code may be a three-character alphabetic or three-digit numeric. The two leftmost characters of the alphabetic code identify the currency authority to which the code is assigned (using the two character alphabetic code from ISO 3166, if applicable). The rightmost character is a mnemonic derived from the name of the major currency unit or fund. For currencies not associated with a single geographic entity, a specially-allocated two-character alphabetic code, in the range XA to XZ identifies the currency authority. The rightmost character is derived from the name of the geographic area concerned, and is mnemonic to the extent possible. The numeric codes are identical to those assigned to the geographic entities listed in ISO 3166. The range 950-998 is reserved for identification of funds and currencies not associated with a single entity listed in ISO 3166.

22 States and Outlying Areas of the U.S.

SIMPLE DATA ELEMENT/CODE REFERENCES

66/SJ, 771/009, 235/A5, 156

SOURCE

National Zip Code and Post Office Directory

AVAILABLE FROM

U.S. Postal Service
National Information Data Center
P.O. Box 2977
Washington, DC 20013

ABSTRACT

Provides names, abbreviations, and codes for the 50 states, the District of Columbia, and the outlying areas of the U.S. The entities listed are considered to be the first order divisions of the U.S.

Microfiche available from NTIS (same as address above).
The Canadian Post Office lists the following as “official” codes for Canadian Provinces:

AB - Alberta
BC - British Columbia
MB - Manitoba
NB - New Brunswick
NF - Newfoundland
NS - Nova Scotia
NT - North West Territories
ON - Ontario
PE - Prince Edward Island
PQ - Quebec
SK - Saskatchewan
YT - Yukon

43 FIPS-55 (Named Populated Places)

SIMPLE DATA ELEMENT/CODE REFERENCES

66/19, 309/FI

SOURCE

Named Populated Places, Primary County Divisions, and Other Locational Entities of the United States.

AVAILABLE FROM

National Technical Information Service
5285 Port Royal Road
Springfield, VA 22161

ABSTRACT

Provides a unique numeric place code for a locational entity within each state and state-equivalent within the United States. Entries include incorporated, unincorporated, and census designated places, Indian reservations, townships, military bases and airports. For a unique code within the United States, the two character state ID (A22) must precede this code.

51 ZIP Code

SIMPLE DATA ELEMENT/CODE REFERENCES

66/16, 309/PQ, 309/PR, 309/PS, 771/010, 116

SOURCE

National ZIP Code and Post Office Directory, Publication 65

The USPS Domestic Mail Manual

AVAILABLE FROM

U.S Postal Service
Washington, DC 20260

New Orders
Superintendent of Documents

P.O. Box 371954
Pittsburgh, PA 15250-7954

ABSTRACT

The ZIP Code is a geographic identifier of areas within the United States and its territories for purposes of expediting mail distribution by the U.S. Postal Service. It is five or nine numeric digits. The ZIP Code structure divides the U.S. into ten large groups of states. The leftmost digit identifies one of these groups. The next two digits identify a smaller geographic area within the large group. The two rightmost digits identify a local delivery area. In the nine-digit ZIP Code, the four digits that follow the hyphen further subdivide the delivery area. The two leftmost digits identify a sector which may consist of several large buildings, blocks or groups of streets. The rightmost digits divide the sector into segments such as a street, a block, a floor of a building, or a cluster of mailboxes.

The USPS Domestics Mail Manual includes information on the use of the new 11-digit zip code.

77 X12 Directories

SIMPLE DATA ELEMENT/CODE REFERENCES

721, 725

SOURCE

X12.3 Data Element Dictionary
X12.22 Segment Directory

AVAILABLE FROM

Data Interchange Standards Association, Inc. (DISA)
Suite 200
1800 Diagonal Road
Alexandria, VA 22314-2852

ABSTRACT

The data element dictionary contains the format and descriptions of data elements used to construct X12 segments. It also contains code lists associated with these data elements. The segment directory contains the format and definitions of the data segments used to construct X12 transaction sets.

121 Health Industry Identification Number

SIMPLE DATA ELEMENT/CODE REFERENCES

128/HI, 66/21, I05/20, 1270/HI

SOURCE

Health Industry Number Database

AVAILABLE FROM

Health Industry Business Communications Council
5110 North 40th Street
Phoenix, AZ 85018

ABSTRACT

The HIN is a coding system, developed and administered by the Health Industry Business Communications Council, that assigns a unique code number to hospi-

tals and other provider organizations - the customers of health industry manufacturers and distributors.

130 Health Care Financing Administration Common Procedural Coding System

SIMPLE DATA ELEMENT/CODE REFERENCES

235/HC, 1270/BO, 1270/BP

SOURCE

Health Care Finance Administration Common Procedural Coding System

AVAILABLE FROM

www.hcfa.gov/medicare/hcpcs.htm
Health Care Financing Administration
Center for Health Plans and Providers
CCPP/DCPC
C5-08-27
7500 Security Boulevard
Baltimore, MD 21244-1850

ABSTRACT

HCPCS is Health Care Finance Administration's (HFCA) coding scheme to group procedures performed for payment to providers.

131 International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

SIMPLE DATA ELEMENT/CODE REFERENCES

235/ID, 235/DX, 1270/BF, 1270/BJ, 1270/BK, 1270/BN, 1270/BQ, 1270/BR, 1270/SD, 1270/TD, 1270/DD, 128/ICD

SOURCE

International Classification of Diseases, 9th Revision, Clincal Modification (ICD-9-CM)

AVAILABLE FROM

U.S. National Center for Health Statistics
Commission of Professional and Hospital Activities
1968 Green Road
Ann Arbor, MI 48105

ABSTRACT

The International Classification of Diseases, 9th Revision, Clinical Modification, describes the classification of morbidity and mortality information for statistical purposes and for the indexing of hospital records by disease and operations.

133 Current Procedural Terminology (CPT) Codes

SIMPLE DATA ELEMENT/CODE REFERENCES

235/CJ, 1270/BS, 128/CPT

SOURCE

Physicians' Current Procedural Terminology (CPT) Manual

AVAILABLE FROM

Order Department
American Medical Association
515 North State Street
Chicago, IL 60610

ABSTRACT

A listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians.

134 National Drug Code

SIMPLE DATA ELEMENT/CODE REFERENCES

235/ND, 1270/NDC

SOURCE

Blue Book, Price Alert, National Drug Data File

AVAILABLE FROM

First Databank, The Hearst Corporation
1111 Bayhill Drive
San Bruno, CA 94066

ABSTRACT

The National Drug Code is a coding convention established by the Food and Drug Administration to identify the labeler, product number, and package sizes of FDA-approved prescription drugs. There are over 170,000 National Drug Codes on file.

135 American Dental Association Codes

SIMPLE DATA ELEMENT/CODE REFERENCES

235/AD, 1270/JO, 1270/JP

SOURCE

Current Dental Terminology (CDT) Manual

AVAILABLE FROM

Salable Materials
American Dental Association
211 East Chicago Avenue
Chicago, IL 60611-2678

ABSTRACT

The CDT contains the American Dental Association's codes for dental procedures and nomenclature and is the nationally accepted set of numeric codes and descriptive terms for reporting dental treatments.

237 Place of Service from Health Care Financing Administration Claim Form

SIMPLE DATA ELEMENT/CODE REFERENCES

1332/B

SOURCE

Electronic Media Claims National Standard Format

AVAILABLE FROM

www.hcfa.gov/medicare/poscode.htm
Health Care Financing Administration
Center for Health Plans and Providers
7500 Security Blvd.
Baltimore, MD 21244-1850
Contact: Patricia Gill

ABSTRACT

A variety of codes indicating place where service was rendered.

307 National Association of Boards of Pharmacy Number

SIMPLE DATA ELEMENT/CODE REFERENCES

128/D3

SOURCE

National Association of Boards of Pharmacy Database and Listings

AVAILABLE FROM

National Council for Prescription Drug Programs
4201 North 24th Street, Suite 365
Phoenix, AZ 85016

ABSTRACT

A unique number assigned in the U.S. and its territories to individual clinic, hospital, chain, and independent pharmacy locations that conduct business at retail by billing third-party drug benefit payers. The National Council for Prescription Drug Programs (NCPDP) maintains this database under contract from the National Association of Boards of Pharmacy. The National Association of Boards of Pharmacy is a seven-digit numeric number with the following format SSNNNNC, where SS=NCPDP assigned state code number, NNNN=NCPDP assigned pharmacy location number, and C=check digit calculated by algorithm from previous six digits.

411 Remittance Remark Codes

SIMPLE DATA ELEMENT/CODE REFERENCES

1270/HE, 1271

SOURCE

Medicare Part A Specification for the ASC X12 835 (7/1/94)
or
Medicare Part B Specification for the ASC X12 835 (7/1/94)
or
National Standard Format Electronic Remittance Advice (Version 001.04)

AVAILABLE FROM

Washington Publishing Company
http://www.wpc-edi.com
or
Health Care Financing Administration (HCFA)
http://www.hcfa.gov/medicare/edi/edi.htm

ABSTRACT

These codes represent non-financial information critical to understanding the adjudication of a health insurance claim.

507 Health Care Claim Status Category Code

SIMPLE DATA ELEMENT/CODE REFERENCES

1271

SOURCE

Health Care Claim Status Category Code

AVAILABLE FROM

Washington Publishing Company
http://www.wpc-edi.com

ABSTRACT

Code used to organize the Health Care Claim Status Codes into logical groupings

508 Health Care Claim Status Code

SIMPLE DATA ELEMENT/CODE REFERENCES

1271

SOURCE

Health Care Claim Status Code

AVAILABLE FROM

Washington Publishing Company
http://www.wpc-edi.com

ABSTRACT

Code identifying the status of an entire claim or service line

513 Home Infusion EDI Coalition (HIEC) Product/Service Code List

SIMPLE DATA ELEMENT/CODE REFERENCES

235/IV

SOURCE

Home Infusion EDI Coalition (HIEC) Coding System

AVAILABLE FROM

HIEC Chairperson
HIBCC (Health Industry Business Communications Council)
5110 North 40th Street
Suite 250
Phoenix, AZ 85018

ABSTRACT

This list contains codes identifying home infusion therapy products/services.

530 National Council for Prescription Drug Programs Reject/Payment Codes

SIMPLE DATA ELEMENT/CODE REFERENCES

1270/RX, 1271

SOURCE

National Council for Prescription Drug Programs Data Dictionary

AVAILABLE FROM

NCPDP
4201 North 24th Street
Suite 365
Phoenix, AZ 85016

ABSTRACT

A listing of NCPDPs payment and reject reason codes, the explanation of the code, and the field number in error (if rejected).

537 Health Care Financing Administration National Provider Identifier

SIMPLE DATA ELEMENT/CODE REFERENCES

128/HPI

SOURCE

National Provider System

AVAILABLE FROM

Health Care Financing Administration
Office of Information Services
Security and Standards Group
Director, Division of Health Care Information Systems
7500 Security Boulevard
Baltimore, MD 21244-1850

ABSTRACT

The Health Care Financing Administration is developing the National Provider Identifiers, which is proposed as the standard unique identifier for each health care provider under the Health Insurance Portability and Accountability Act of 1996.

540 Health Care Financing Administration National PlanID

SIMPLE DATA ELEMENT/CODE REFERENCES

66/XV

SOURCE

PlanID Database

AVAILABLE FROM

Health Care Financing Administration
Center for Beneficiary Services
Administration Group
Division of Membership Operations
S1-05-06
7500 Security Boulevard
Baltimore, MD 21244-1850

ABSTRACT

The Health care Financing Administration is developing the PlanID, which will be proposed as the standard unique identifier for each health plan under the Health Insurance Portability and Accountability Act of 1996.

DOD1 Military Rank and Health Care Service Region

SIMPLE DATA ELEMENT/CODE REFERENCES

1038, 309RJ

SOURCE

Military Health Systems Functional Area Manual - Data

AVAILABLE FROM

Health Affairs Functional Data Administrator
TRICARE Management Activity
Information Management Technology and Reengineering, FI and DA
5111 Leesburg Pike Suite 810
Falls Church, VA 22041-3206

ABSTRACT

(rank): The Department of Defense Rank code expresses the code associated with the specific military rank for all military personnel.

(region): The Department of Defense Health Care Service Region code indicates the specific domestic or foreign regions that administer health benefits for military personnel.

DOD2 Paygrade

SIMPLE DATA ELEMENT/CODE REFERENCES

1038

SOURCE

Department of Defense Instruction (DODI) 1000.13
Sponsor Information - Block 7
Rank / Paygrade

AVAILABLE FROM

Office of the Deputy Undersecretary of Defense for Program Integration
Department of Defense
4000 Defense Pentagon
Washington, DC 20301-4000

ABSTRACT

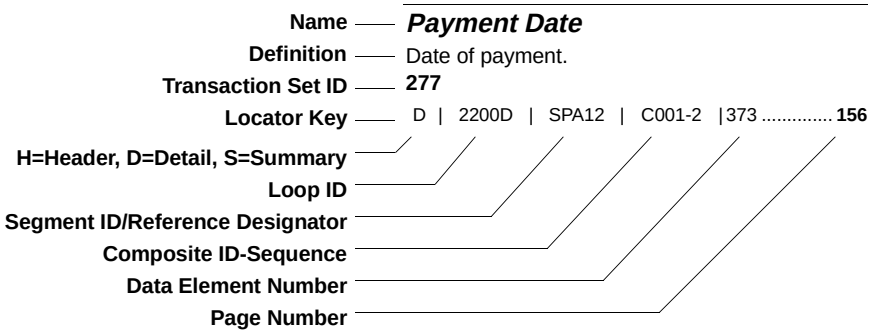
The Department of Defense Rank and Paygrade expresses the rank and paygrade code for military personnel.

D Change Summary

This is the first ASC X12N implementation guide for the 270/271. In future guides, this section will contain a summary of all changes since the previous guide.

E Data Element Name Index

This appendix contains an alphabetic listing of data elements used in this implementation guide. Consult the Data Element Dictionary for the complete list. Data element names in normal type are generic ASC X12 names. Italic type indicates a health care industry defined name.



Amount Qualifier Code

Code to qualify amount.

270
D | 2110C | AMT01 | - | 522 ..... **99**

Authorization or Certification Indicator

A yes/no indicator that identifies whether an authorization or certification is required per plan provisions.

271
D | 2110C | EB11 | - | 1073 ..... **230**
D | 2110D | EB11 | - | 1073 ..... **307**

Benefit Amount

Benefit amount as qualifed by the elgibility or benefit information and service type code

271
D | 2110C | EB07 | - | 782 ..... **229**
D | 2110D | EB07 | - | 782 ..... **305**

Benefit Coverage Level Code

Code indicating which family members are provided coverge for this insured.

270
D | 2110C | EQ03 | - | 1207 ..... **97**
D | 2110D | EQ03 | - | 1207 ..... **139**

271
D | 2110C | EB02 | - | 1207 ..... **221**
D | 2110D | EB02 | - | 1207 ..... **298**

Benefit Percent

Benefit percentage as qualifed by the elgibility or benefit information and service type code

271
D | 2110C | EB08 | - | 954 ..... **229**
D | 2110D | EB08 | - | 954 ..... **306**

Benefit Quantity

Benefit quantity as qualified by preceeding qualifier.

271
D | 2110C | EB10 | - | 380 ..... **230**
D | 2110C | HSD02 | - | 380 ..... **234**
D | 2110D | EB10 | - | 380 ..... **306**
D | 2110D | HSD02 | - | 380 ..... **310**

Benefit Related Entity Address Line

Street Address of the entity related to benefits described in the transaction.

271
D | 2120C | N301 | - | 166 ..... **254**
D | 2120C | N302 | - | 166 ..... **254**
D | 2120D | N301 | - | 166 ..... **330**
D | 2120D | N302 | - | 166 ..... **330**

Benefit Related Entity City Name

The city name of the entity related to benefits described in the transaction.

271
D | 2120C | N401 | - | 19 ..... **255**
D | 2120D | N401 | - | 19 ..... **331**

Benefit Related Entity Communication Number

Communications number to contact the person, group or organization identified as the associated benefit related entity contact name.

271
D | 2120C | PER04 | - | 364 ..... **259**
D | 2120C | PER06 | - | 364 ..... **259**

Benefit Related Entity Contact Name

The name at the benefit related entity to whom inquiries about the transaction may be directed.

271

Benefit Related Entity First Name

The first name of the person identified as the benefit related entity, ofr an individual subscriber or dependent.

271

Benefit Related Entity Identifier

Unique identifier for a benefit related entity or another information source associated with an individual subscriber or dependent.

271

Benefit Related Entity Last or Organization Name

Lat name or organization name of the benefit related entity associated with an individual subscriber or dependent.

271

Benefit Related Entity Middle Name

Middle name of the benefit related entity associated with an individual subscriber or dependent.

271

Benefit Related Entity Name Suffix

Suffix for the name of the benefit related entity associated with an individual subscriber or dependent.

271

Benefit Related Entity Postal Zone or ZIP Code

The postal zone or ZIP Code of the entity associated with benefits described in the transaction.

271

Benefit Related Entity State Code

The state postal code of the entity related to benefits described in the transaction.

271

Birth Sequence Number

A number indicating the order of birth for the identified person in relationship to family members with the same date of birth.

270

271

Code List Qualifier Code

Code identifying a specific industry code list.

270

271

Communication Number Qualifier

Code identifying the type of communication number

270

271

Contact Function Code

Code identifying the major duty or responsibility of the person or group named.

270

D	2100B	PER01	-	366	.....	**61**

271

D	2100A	PER01	-	366	.....	**169**
D	2100C	PER01	-	366	.....	**204**
D	2120C	PER01	-	366	.....	**258**
D	2100D	PER01	-	366	.....	**281**
D	2120D	PER01	-	366	.....	**334**

Country Code

Code indicating the geographic location.

270

D	2100B	N404	-	26	.....	**59**
D	2100C	N404	-	26	.....	**79**
D	2100D	N404	-	26	.....	**120**

271

D	2100C	N404	-	26	.....	**202**
D	2120C	N404	-	26	.....	**256**
D	2100D	N404	-	26	.....	**279**
D	2120D	N404	-	26	.....	**332**

Date Time Period

Expression of a date, a time, or a range of dates, times, or dates and times.

270

D	2100C	DTP03	-	1251	.....	**88**
D	2110C	DTP03	-	1251	.....	**107**
D	2100D	DTP03	-	1251	.....	**130**
D	2110D	DTP03	-	1251	.....	**146**

271

D	2100C	DTP03	-	1251	.....	**217**
D	2100D	DTP03	-	1251	.....	**294**

Date Time Period Format Qualifier

Code indicating the date format, time format, or date and time format

270

D	2100C	DMG01	-	1250	.....	**84**
D	2100C	DTP02	-	1250	.....	**88**
D	2110C	DTP02	-	1250	.....	**107**
D	2100D	DMG01	-	1250	.....	**125**
D	2100D	DTP02	-	1250	.....	**130**
D	2110D	DTP02	-	1250	.....	**146**

271

D	2100C	DMG01	-	1250	.....	**211**
D	2100C	DTP02	-	1250	.....	**217**
D	2110C	DTP02	-	1250	.....	**241**
D	2100D	DMG01	-	1250	.....	**288**
D	2100D	DTP02	-	1250	.....	**294**
D	2110D	DTP02	-	1250	.....	**317**

Date Time Qualifier

Code specifying the type of date or time or both date and time.

270

D	2100C	DTP01	-	374	.....	**88**
D	2110C	DTP01	-	374	.....	**106**
D	2100D	DTP01	-	374	.....	**130**
D	2110D	DTP01	-	374	.....	**145**

271

D	2100C	DTP01	-	374	.....	**216**
D	2110C	DTP01	-	374	.....	**240**
D	2100D	DTP01	-	374	.....	**293**
D	2110D	DTP01	-	374	.....	**316**

Delivery Frequency Code

Code which specifies frequency by which services can be peformed.

271

D	2110C	HSD07	-	678	.....	**235**
D	2110D	HSD07	-	678	.....	**311**

Delivery Pattern Time Code

Code which specifies the time delivery pattern of the services..

271

D	2110C	HSD08	-	679	.....	**237**
D	2110D	HSD08	-	679	.....	**313**

Department of Defense Health Service Region Code

Code identifying the health service region established by the department of defense.

271

D	2120C	N406	-	310	.....	**256**
D	2120D	N406	-	310	.....	**332**

Dependent Address Line

The street address of the patient.

270

D	2100D	N301	-	166	.....	**118**
D	2100D	N302	-	166	.....	**118**

271

D	2100D	N301	-	166	.....	**277**
D	2100D	N302	-	166	.....	**277**

Dependent Birth Date

The date of birth of the dependent.

270

D	2100D	DMG02	-	1251	.....	**125**

271

D	2100D	DMG02	-	1251	.....	**288**

Dependent City Name

The city name of the patient.

270

D	2100D	N401	-	19	.....	**119**

271

D	2100D	N401	-	19	.....	**278**

Dependent Contact Name

Name of person to contact for information concerning dependent.

271
D | 2100D | PER02 | - | 93 ..... **281**

Dependent Contact Number

Contact number for the dependent's contact person or entity.

271
D | 2100D | PER04 | - | 364 ..... **282**
D | 2100D | PER06 | - | 364 ..... **282**
D | 2100D | PER08 | - | 364 ..... **283**

Dependent Eligibility or Benefit Identifier

Number associated with the dependent for the eligibility or benefit being described.

271
D | 2110D | REF02 | - | 127 ..... **315**

Dependent First Name

The first name of the dependent.

270
D | 2100D | NM104 | - | 1036 .....**115**

271
D | 2100D | NM104 | - | 1036 ..... **272**

Dependent Gender Code

A code indicating the gender of the dependent.

270
D | 2100D | DMG03 | - | 1068 ..... **125**

271
D | 2100D | DMG03 | - | 1068 ..... **288**

Dependent Last Name

The last name of the dependent.

270
D | 2100D | NM103 | - | 1035 .....**115**

271
D | 2100D | NM103 | - | 1035 ..... **272**

Dependent Middle Name

The middle name of the dependent.

270
D | 2100D | NM105 | - | 1037 .....**115**

271
D | 2100D | NM105 | - | 1037 ..... **272**

Dependent Name Suffix

A suffix following the name, including the generation of the patient, such as I, II, III, Jr, Sr.

270
D | 2100D | NM107 | - | 1039 .....**115**

271
D | 2100D | NM107 | - | 1039 ..... **272**

Dependent Postal Zone or ZIP Code

The zip code of the dependent.

270
D | 2100D | N403 | - | 116..... **120**

271
D | 2100D | N403 | - | 116..... **279**

Dependent Primary Identifier

Identifies the code number by which the dependent is known.

271
D | 2100D | NM109 | - | 67 ..... **273**

Dependent State Code

The state postal code of the dependent.

270
D | 2100D | N402 | - | 156 ..... **120**

271
D | 2100D | N402 | - | 156 ..... **279**

Dependent Supplemental Identifier

Identifies another or additional distinguishing code number associated with the dependent

270
D | 2100D | REF02 | - | 127 .....**117**

271
D | 2100D | REF02 | - | 127 ..... **276**

Eligibility or Benefit Date Time Period

Date or period associated with the eligibility or benefit being described.

271
D | 2110C | DTP03 | - | 1251 ..... **241**
D | 2110D | DTP03 | - | 1251 ..... **317**

Eligibility or Benefit Information

Benefit status of the individual or benefit related category to be further described in the transaction.

271
D | 2110C | EB01 | - | 1390 ..... **219**
D | 2110D | EB01 | - | 1390 ..... **296**

Entity Identifier Code

Code identifying an organizational entity, a physical location, property or an individual

270
D | 2100A | NM101 | - | 98 ..... **44**
D | 2100B | NM101 | - | 98 ..... **50**

D	2100C	NM101	-	98		**71**
D	2100D	NM101	-	98		**114**

271

D	2100A	NM101	-	98		**163**
D	2100B	NM101	-	98		**178**
D	2100C	NM101	-	98		**193**
D	2120C	NM101	-	98		**250**
D	2100D	NM101	-	98		**271**
D	2120D	NM101	-	98		**326**

Entity Type Qualifier

Code qualifying the type of entity

270

D	2100A	NM102	-	1065		**45**
D	2100B	NM102	-	1065		**51**
D	2100C	NM102	-	1065		**72**
D	2100D	NM102	-	1065		**115**

271

D	2100A	NM102	-	1065		**164**
D	2100B	NM102	-	1065		**179**
D	2100C	NM102	-	1065		**194**
D	2120C	NM102	-	1065		**251**
D	2100D	NM102	-	1065		**272**
D	2120D	NM102	-	1065		**327**

Follow-up Action Code

Code identifying follow-up actions allowed.

271

D	2000A	AAA04	-	889		**161**
D	2100A	AAA04	-	889		**174**
D	2100B	AAA04	-	889		**186**
D	2100C	AAA04	-	889		**209**
D	2110C	AAA04	-	889		**243**
D	2100D	AAA04	-	889		**286**
D	2110D	AAA04	-	889		**319**

Free Form Message Text

Text used to convey information related to the transaction.

271

D	2110C	MSG01	-	933		**244**
D	2110D	MSG01	-	933		**320**

Handicap Indicator

Code indicating if individual is handicapped or not.

271

D	2100C	INS10	-	1073		**214**
D	2100D	INS10	-	1073		**291**

Hierarchical Child Code

Code indicating if there are hierarchical child data segments subordinate to the level being described.

270

D	2000A	HL04	-	736		**43**
D	2000B	HL04	-	736		**49**
D	2000C	HL04	-	736		**68**
D	2000D	HL04	-	736		**111**

271

D	2000A	HL04	-	736		**159**
D	2000B	HL04	-	736		**177**
D	2000C	HL04	-	736		**189**
D	2000D	HL04	-	736		**267**

Hierarchical ID Number

A unique number assigned by the sender to identify a particular data segment in a hierarchical structure.

270

D	2000A	HL01	-	628		**42**
D	2000B	HL01	-	628		**48**
D	2000C	HL01	-	628		**67**
D	2000D	HL01	-	628		**110**

271

D	2000A	HL01	-	628		**159**
D	2000B	HL01	-	628		**176**
D	2000C	HL01	-	628		**188**
D	2000D	HL01	-	628		**266**

Hierarchical Level Code

Code defining the characteristic of a level in a hierarchical structure.

270

D	2000A	HL03	-	735		**42**
D	2000B	HL03	-	735		**48**
D	2000C	HL03	-	735		**68**
D	2000D	HL03	-	735		**111**

271

D	2000A	HL03	-	735		**159**
D	2000B	HL03	-	735		**176**
D	2000C	HL03	-	735		**189**
D	2000D	HL03	-	735		**266**

Hierarchical Parent ID Number

Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to.

270

D	2000B	HL02	-	734		**48**
D	2000C	HL02	-	734		**68**
D	2000D	HL02	-	734		**110**

271

D	2000B	HL02	-	734		**176**
D	2000C	HL02	-	734		**188**
D	2000D	HL02	-	734		**266**

Hierarchical Structure Code

Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set

270

H		BHT01	-	1005		**38**

271

H		BHT01	-	1005		**156**

Identification Code Qualifier

Code designating the system/method of code structure used for Identification Code (67)

270

D	2100A	NM108	-	66		**46**
D	2100B	NM108	-	66		**52**

D | 2100C | NM108 | - | 66 ..... **73**

271

D | 2100A | NM108 | - | 66 ..... **165**
D | 2100B | NM108 | - | 66 ..... **180**
D | 2100C | NM108 | - | 66 ..... **195**
D | 2120C | NM108 | - | 66 ..... **252**
D | 2100D | NM108 | - | 66 ..... **273**
D | 2120D | NM108 | - | 66 ..... **328**

In Plan Network Indicator

A yes/no indicator that specifies whether or not services from the requested provider were provided within the health plan network or not.

271

D | 2110C | EB12 | - | 1073 ..... **230**
D | 2110D | EB12 | - | 1073 ..... **307**

Individual Relationship Code

Code indicating the relationship between two individuals or entities

270

D | 2100C | INS02 | - | 1069 ..... **86**
D | 2100D | INS02 | - | 1069 ..... **127**

271

D | 2100C | INS02 | - | 1069 ..... **213**
D | 2100D | INS02 | - | 1069 ..... **290**

Industry Code

Code indicating a code from a specific industry code list.

270

D | 2110C | III02 | - | 1271 ..... **103**
D | 2110D | III02 | - | 1271 ..... **142**

271

D | 2115C | III02 | - | 1271 ..... **248**
D | 2115D | III02 | - | 1271 ..... **324**

Information Receiver Additional Address Line

The Information Receiver's additional address information.

270

D | 2100B | N302 | - | 166 ..... **57**

Information Receiver Additional Identifier

Identifies another or additional distinguishing code number associated with the receiver of information.

270

D | 2100B | REF02 | - | 127 ..... **56**

271

D | 2100B | REF02 | - | 127 ..... **183**

Information Receiver Address Line

The Information Receiver's address.

270

D | 2100B | N301 | - | 166 ..... **57**

Information Receiver City Name

The City Name of the Information Receiver's address.

270

D | 2100B | N401 | - | 19 ..... **58**

Information Receiver Communication Number

Contact number for the designated person or entity for the information receiver.

270

D | 2100B | PER04 | - | 364 ..... **62**
D | 2100B | PER06 | - | 364 ..... **62**
D | 2100B | PER08 | - | 364 ..... **63**

Information Receiver Contact Name

Individual at information receiver to whom inquiries about this transaction should be directed.

270

D | 2100B | PER02 | - | 93 ..... **61**

Information Receiver First Name

The first name of the individual or organization who expects to receive information in response to a query.

270

D | 2100B | NM104 | - | 1036 ..... **51**

271

D | 2100B | NM104 | - | 1036 ..... **179**

Information Receiver Identification Number

The identification number of the individual or organization who expects to receive information in response to a query.

270

D | 2100B | NM109 | - | 67 ..... **52**

271

D | 2100B | NM109 | - | 67 ..... **181**

Information Receiver Last or Organization Name

The name of the organization or last name of the individual that expects to receive information or is receving information..

270

D | 2100B | NM103 | - | 1035 ..... **51**

271
D | 2100B | NM103 | - | 1035 ..... **179**

Information Receiver Middle Name

The middle name of the individual or organization who expects to receive information in response to a query.

270
D | 2100B | NM105 | - | 1037 ..... **51**

271
D | 2100B | NM105 | - | 1037 ..... **179**

Information Receiver Name Suffix

The suffix to the name of the individual or organization who expects to receive information in response to a query.

270
D | 2100B | NM107 | - | 1039 ..... **51**

271
D | 2100B | NM107 | - | 1039 ..... **179**

Information Receiver Postal Zone or ZIP Code

The Zip Code of the Information Receiver's address.

270
D | 2100B | N403 | - | 116..... **59**

Information Receiver State Code

The State Postal Code of the Information Receiver's address.

270
D | 2100B | N402 | - | 156 ..... **59**

Information Source Additional Plan Identifier

An additional code number by which the information source is known to the information receiver.

271
D | 2100A | REF02 | - | 127 ..... **167**

Information Source Communication Number

Contact number for the designated person or entity for the information source.

271
D | 2100A | PER04 | - | 364 ..... **170**
D | 2100A | PER06 | - | 364 ..... **170**
D | 2100A | PER08 | - | 364 ..... **171**

Information Source Contact Name

Information source contact name to whom inquiries about this transaction should be directed.

271
D | 2100A | PER02 | - | 93 ..... **169**

Information Source First Name

First name of an individual who is the source of the information.

270
D | 2100A | NM104 | - | 1036 ..... **45**

271
D | 2100A | NM104 | - | 1036 ..... **164**

Information Source Last or Organization Name

The organization name or the last name of an individual who is the source of the information.

270
D | 2100A | NM103 | - | 1035 ..... **45**

271
D | 2100A | NM103 | - | 1035 ..... **164**

Information Source Middle Name

Middle name of an individual who is the source of the information.

270
D | 2100A | NM105 | - | 1037 ..... **45**

271
D | 2100A | NM105 | - | 1037 ..... **164**

Information Source Name Suffix

Suffix to the name of the individual who is the source of the information.

270
D | 2100A | NM107 | - | 1039 ..... **45**

271
D | 2100A | NM107 | - | 1039 ..... **164**

Information Source Primary Identifier

Identifies the number by which the information source is known to the information receiver.

270
D | 2100A | NM109 | - | 67 ..... **46**

271
D | 2100A | NM109 | - | 67 ..... **165**

Insurance Type Code

Code identifying the type of insurance.

270
D | 2110C | EQ04 | - | 1336 ..... **97**

D | 2110D | EQ04 | - | 1336 ..... **139**

271

D | 2110C | EB04 | - | 1336 ..... **226**
D | 2110D | EB04 | - | 1336 ..... **303**

Insured Indicator

Indicates whether the insured is the subscriber or a dependent.

270

D | 2100C | INS01 | - | 1073 ..... **86**
D | 2100D | INS01 | - | 1073 ..... **127**

271

D | 2100C | INS01 | - | 1073 ..... **213**
D | 2100D | INS01 | - | 1073 ..... **290**

License Number State Code

The State Postal Code of a jurisdiction-assigned license number.

270

D | 2100B | REF03 | - | 352 ..... **56**

271

D | 2100B | REF03 | - | 352 ..... **183**

Location Identification Code

Code which identifies a specific location.

271

D | 2100C | N406 | - | 310 ..... **202**

Location Qualifier

Code identifying type of location.

271

D | 2100C | N405 | - | 309 ..... **202**
D | 2120C | N405 | - | 309 ..... **256**
D | 2120D | N405 | - | 309 ..... **332**

Loop Identifier Code

The loop ID number given on the transaction set diagram is the value for this data element in segments LS and LE.

271

D | 2110C | LS01 | - | 447 ..... **249**
D | 2110C | LE01 | - | 447 ..... **264**
D | 2110D | LS01 | - | 447 ..... **325**
D | 2110D | LE01 | - | 447 ..... **340**

Maintenance Reason Code

Code identifying reason for the maintenance change

271

D | 2100C | INS04 | - | 1203 ..... **214**
D | 2100D | INS04 | - | 1203 ..... **291**

Maintenance Type Code

Code identifying a specific type of item maintenance

271

D | 2100C | INS03 | - | 875 ..... **213**
D | 2100D | INS03 | - | 875 ..... **290**

Period Count

Total number of periods

271

D | 2110C | HSD06 | - | 616 ..... **235**
D | 2110D | HSD06 | - | 616 ..... **311**

Plan Coverage Description

A description or number that identifies the plan or coverage

271

D | 2110C | EB05 | - | 1204 ..... **228**
D | 2110D | EB05 | - | 1204 ..... **305**

Plan Name

A free-form text field to provide the health plan name for the related data elements in the segment.

271

D | 2100A | REF03 | - | 352 ..... **167**

Plan Sponsor Name

The name of the entity providing coverage to the subscriber.

271

D | 2100C | REF03 | - | 352 ..... **199**
D | 2110C | REF03 | - | 352 ..... **239**
D | 2100D | REF03 | - | 352 ..... **276**
D | 2110D | REF03 | - | 352 ..... **315**

Prior Authorization or Referral Number

A number, code or other value that indicates the services provided on this claim have been authorized by the payee or other service organization, or that a referral for services has been approved.

270

D | 2110C | REF02 | - | 127 ..... **105**
D | 2110D | REF02 | - | 127 ..... **144**

Procedure Code

Code identifying the procedure, product or service.

270

D | 2110C | EQ02 | C003-2 | 234 ..... **96**
D | 2110D | EQ02 | C003-2 | 234 ..... **138**

271

D | 2110C | EB13 | C003-2 | 234 ..... **231**
D | 2110D | EB13 | C003-2 | 234 ..... **308**

Procedure Modifier

This identifies special circumstances related to the performance of the service.

270

D | 2110C | EQ02 | C003-3 | 1339 ..... **96**
D | 2110C | EQ02 | C003-4 | 1339 ..... **96**

D	2110C	EQ02	C003-5	1339	**96**
D	2110C	EQ02	C003-6	1339	**96**
D	2110D	EQ02	C003-3	1339	**138**
D	2110D	EQ02	C003-4	1339	**138**
D	2110D	EQ02	C003-5	1339	**138**
D	2110D	EQ02	C003-6	1339	**138**

271

D	2110C	EB13	C003-3	1339	**231**
D	2110C	EB13	C003-4	1339	**231**
D	2110C	EB13	C003-5	1339	**231**
D	2110C	EB13	C003-6	1339	**232**
D	2110D	EB13	C003-3	1339	**308**
D	2110D	EB13	C003-4	1339	**308**
D	2110D	EB13	C003-5	1339	**308**
D	2110D	EB13	C003-6	1339	**308**

Product or Service ID Qualifier

Code identifying the type/source of the descriptive number used in Product/Service ID (234).

270

D	2110C	EQ02	C003-1	235	**95**
D	2110D	EQ02	C003-1	235	**137**

271

D	2110C	EB13	C003-1	235	**231**
D	2110D	EB13	C003-1	235	**307**

Provider Code

Code identifying the type of provider.

270

D	2100B	PRV01	-	1221	**64**
D	2100C	PRV01	-	1221	**81**
D	2100D	PRV01	-	1221	**122**

271

D	2120C	PRV01	-	1221	**262**
D	2120D	PRV01	-	1221	**338**

Provider Identifier

Number assigned by the payer, regulatory authority, or other authorized body or agency to identify the provider.

270

D	2100C	PRV03	-	127	**82**
D	2100D	PRV03	-	127	**123**

271

D	2120C	PRV03	-	127	**263**
D	2120D	PRV03	-	127	**339**

Quantity Qualifier

Code specifying the type of quantity

271

D	2110C	EB09	-	673	**229**
D	2110C	HSD01	-	673	**234**
D	2110D	EB09	-	673	**306**
D	2110D	HSD01	-	673	**310**

Receiver Provider Specialty Code

Identifies another or distinguishing number for a provider.

270

D	2100B	PRV03	-	127	**65**

Reference Identification Qualifier

Code qualifying the reference identification

270

D	2100B	REF01	-	128	**54**
D	2100B	PRV02	-	128	**65**
D	2100C	REF01	-	128	**75**
D	2100C	PRV02	-	128	**82**
D	2110C	REF01	-	128	**104**
D	2100D	REF01	-	128	**116**
D	2100D	PRV02	-	128	**123**
D	2110D	REF01	-	128	**143**

271

D	2100A	REF01	-	128	**166**
D	2100B	REF01	-	128	**182**
D	2100C	REF01	-	128	**197**
D	2110C	REF01	-	128	**238**
D	2120C	PRV02	-	128	**262**
D	2100D	REF01	-	128	**275**
D	2110D	REF01	-	128	**314**
D	2120D	PRV02	-	128	**338**

Reject Reason Code

Code assigned by issuer to identify reason for rejection

271

D	2000A	AAA03	-	901	**161**
D	2100A	AAA03	-	901	**173**
D	2100B	AAA03	-	901	**185**
D	2100C	AAA03	-	901	**208**
D	2110C	AAA03	-	901	**243**
D	2100D	AAA03	-	901	**285**
D	2110D	AAA03	-	901	**319**

Sample Selection Modulus

To specify the sampling frequency in terms of a modulus of the Unit of Measure, e.g., every fifth bag, every 1.5 minutes

271

D	2110C	HSD04	-	1167	**234**
D	2110D	HSD04	-	1167	**310**

Service Type Code

Code identifying the classification of service

270

D	2110C	EQ01	-	1365	**90**
D	2110D	EQ01	-	1365	**132**

271

D	2110C	EB03	-	1365	**221**
D	2110D	EB03	-	1365	**298**

Spend Down Amount

Dollar amount subscriber must pay or has paid toward cost of health care before benefits are effective.

270

D	2110C	AMT02	-	782	.....	**100**

Student Status Code

Code indicating the student status of the patient if 19 years of age or older, not handicapped and not the insured

271

D	2100C	INS09	-	1220	.....	**214**
D	2100D	INS09	-	1220	.....	**291**

Submitter Transaction Identifier

Trace or control number assigned by the originator of the transaction

270

H		BHT03	-	127	.....	**39**

271

H		BHT03	-	127	.....	**157**

Subscriber Address Line

Address line of the current mailing address of the insured individual or subscriber to the coverage.

270

D	2100C	N301	-	166	.....	**77**
D	2100C	N302	-	166	.....	**77**

271

D	2100C	N301	-	166	.....	**200**
D	2100C	N302	-	166	.....	**200**

Subscriber Birth Date

The date of birth of the subscriber to the indicated coverage or policy.

270

D	2100C	DMG02	-	1251	.....	**84**

271

D	2100C	DMG02	-	1251	.....	**211**

Subscriber City Name

The City Name of the insured individual or subscriber to the coverage

270

D	2100C	N401	-	19	.....	**78**

271

D	2100C	N401	-	19	.....	**201**

Subscriber Contact Name

Name of the individual to contact on the subscriber's behalf concerning the information in the transaction.

271

D	2100C	PER02	-	93	.....	**204**

Subscriber Contact Number

Telephone number, including area code, at which the subscriber may be contacted.

271

D	2100C	PER04	-	364	.....	**205**
D	2100C	PER06	-	364	.....	**205**
D	2100C	PER08	-	364	.....	**206**

Subscriber Eligibility or Benefit Identifier

Number associated with the subscriber for the eligibility or benefit being described.

271

D	2110C	REF02	-	127	.....	**239**

Subscriber First Name

The first name of the insured individual or subscriber to the coverage

270

D	2100C	NM104	-	1036	.....	**72**

271

D	2100C	NM104	-	1036	.....	**194**

Subscriber Gender Code

Code indicating the sex of the subscriber to the indicated coverage or policy.

270

D	2100C	DMG03	-	1068	.....	**84**

271

D	2100C	DMG03	-	1068	.....	**211**

Subscriber Last Name

The surname of the insured individual or subscriber to the coverage

270

D	2100C	NM103	-	1035	.....	**72**

271

D	2100C	NM103	-	1035	.....	**194**

Subscriber Middle Name

The middle name of the subscriber to the indicated coverage or policy.

270

D	2100C	NM105	-	1037	.....	**72**

271

D	2100C	NM105	-	1037	.....	**194**

Subscriber Name Prefix

The name prefix of the subscriber to the indicated coverage or policy.

271

D	2100C	NM106	-	1038	.....	**194**

Subscriber Name Suffix

Suffix of the insured individual or subscriber to the coverage.

270

D	2100C	NM107	-	1039	.....	**72**

271

D	2100C	NM107	-	1039	.....	**194**

Subscriber Postal Zone or ZIP Code

The ZIP Code of the insured individual or subscriber to the coverage

270

D	2100C	N403	-	116	.....	**79**

271

D	2100C	N403	-	116	.....	**202**

Subscriber Primary Identifier

Primary identification number of the subscriber to the coverage.

270

D	2100C	NM109	-	67	.....	**73**

271

D	2100C	NM109	-	67	.....	**195**

Subscriber State Code

The State Postal Code of the insured individual or subscriber to the coverage

270

D	2100C	N402	-	156	.....	**79**

271

D	2100C	N402	-	156	.....	**202**

Subscriber Supplemental Identifier

Identifies another or additional distinguishing code number associated with the subscriber.

270

D	2100C	REF02	-	127	.....	**76**

271

D	2100C	REF02	-	127	.....	**198**

Time Period Qualifier

Code defining the type of time period.

271

D	2110C	EB06	-	615	.....	**228**
D	2110C	HSD05	-	615	.....	**235**
D	2110D	EB06	-	615	.....	**305**
D	2110D	HSD05	-	615	.....	**311**

Trace Assigning Entity Additional Identifier

Additional identifier for the entity assigning the trace number.

270

D	2000C	TRN04	-	127	.....	**70**
D	2000D	TRN04	-	127	.....	**113**

271

D	2000C	TRN04	-	127	.....	**192**
D	2000D	TRN04	-	127	.....	**270**

Trace Assigning Entity Identifier

Identifies the organization assigning the trace number.

270

D	2000C	TRN03	-	509	.....	**70**
D	2000D	TRN03	-	509	.....	**113**

271

D	2000C	TRN03	-	509	.....	**192**
D	2000D	TRN03	-	509	.....	**270**

Trace Number

Identification number used by originator of the transaction.

270

D	2000C	TRN02	-	127	.....	**70**
D	2000D	TRN02	-	127	.....	**113**

271

D	2000C	TRN02	-	127	.....	**191**
D	2000D	TRN02	-	127	.....	**269**

Trace Type Code

Code identifying the type of reassociation which needs to be performed.

270

D	2000C	TRN01	-	481	.....	**69**
D	2000D	TRN01	-	481	.....	**112**

271

D	2000C	TRN01	-	481	.....	**191**
D	2000D	TRN01	-	481	.....	**269**

Transaction Segment Count

A tally of all segments between the ST and the SE segments including the ST and SE segments.

270

D		SE01	-	96	.....	**147**

271

D	1	SE01	-	96	.....	**341**

Transaction Set Control Number

The unique identification number within a transaction set.

270

H		ST02	-	329	.....	**37**
D		SE02	-	329	.....	**147**

271

H		ST02	-	329	.....	**155**
D	1	SE02	-	329	.....	**341**

Transaction Set Creation Date

Identifies the date the submitter created the transaction

270

H		BHT04	-	373	.....	**39**

271

H		BHT04	-	373	.....	**157**

Transaction Set Creation Time

Time file is created for transmission.

270

H		BHT05	-	337	.....	**40**

271

H		BHT05	-	337	.....	**157**

Transaction Set Identifier Code

Code uniquely identifying a Transaction Set.

270

H		ST01	-	143	.....	**36**

271

H		ST01	-	143	.....	**154**

Transaction Set Purpose Code

Code identifying purpose of transaction set.

270

H		BHT02	-	353	.....	**39**

271

H		BHT02	-	353	.....	**157**

Transaction Type Code

Code specifying the type of transaction.

270

H		BHT06	-	640	.....	**40**

Unit or Basis for Measurement Code

Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken.

271

D	2110C	HSD03	-	355	.....	**234**
D	2110D	HSD03	-	355	.....	**310**

Valid Request Indicator

Code indicating if the information request or portion of the request is valid or invalid.

271

D	2000A	AAA01	-	1073	.....	**160**
D	2100A	AAA01	-	1073	.....	**173**
D	2100B	AAA01	-	1073	.....	**185**
D	2100C	AAA01	-	1073	.....	**207**
D	2110C	AAA01	-	1073	.....	**242**
D	2100D	AAA01	-	1073	.....	**284**
D	2110D	AAA01	-	1073	.....	**318**